THE CLINIQUE.

VOL. XVIII.] CHICAGO, DECEMBER 15, 1897. [No. 12.

Original Lectures.

THE ESSENTIAL PATHOGENESY OF DRUGS.

EXTRACTS FROM LECTURES DELIVERED BY CHAS. H. EVANS, M.D., ASSOCIATE PROFESSOR OF MATERIA MEDICA AND INSTITUTES OF MEDICINE IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, CHICAGO.

ACONITE. In presenting the toxic effects of aconite for your consideration to-day I am not guided in this the first lecture of the session by the fact that the word commences with the first letter of the alphabet, on the contrary the character and relation of drug action will determine the order and succession in which they will be presented to you.

The reason that I have selected this drug for my initial lecture lies in the fact that aconite when taken into the healthy human body causes the simplest and most elementary departure from health that a drug is capable of inducing. The essential influence of aconite predominates in the circulatory system causing frequent and violent beating of the heart with a rapid stream of blood pulsating through the arteries, capillaries and veins, together with redness, dryness and burning heat over the whole body. This state of hyperæmia is a general one, in which all parts of the body equally participate, and the foregoing objective and subjective symptoms are present in each and every organ in the same degree. I use the word hyperæmia not in the sense of stasis but as denoting an increased quantity of blood passing through a definite area at a given moment.

It is exceedingly doubtful if aconite exerts any specific influence upon any tissue or organ independent of those following upon increased circulation and consequent increase of oxydization. So far as a careful study of its provings, voluntary and involuntary, and in all degrees of dosage, is concerned, there is no evidence that aconite influences any locality in any special way except through derangement of the circulation.

In other words, it begins and ends with the production of a primary chill with diminished circulation, succeeded by high fever, thirst and rapid flow of blood, with strongly beating heart or vessels, followed by profuse warm sweating of the whole body and increased flow of urine.

The paroxysm is single, whether it lasts a longer or shorter time, and when it ceases, does not recur again. It is never a continued fever lasting for days or weeks and thus bears no resemblance to typhoid or typhus; it does not expend itself and return to run its course in twenty-four or forty eight hours like an intermittent or a remittent; it never produces a state of degeneration in ultimate structures and has no relation to a septic condition.

The sole diseased process consists in the production of the simplest and earliest change known to pathology, the heart and vessels sending blood with lightning-like rapidity through the body, and so deranging every organic function that they all utter their cries of distress. Such a general condition may be likened to a steam engine that has lost its governor, and as the saying is "runs away with itself." The unwonted supply of blood to all the tissues excites and deranges their functions, and together with the resulting infiltration of serum originates and evokes all the sufferings consequent upon the aconite disease; the various local disturbances result from the general circulatory disorder and not from any hæmic changes. The various sufferings in different parts of the body under the influence of aconite arise from the special anatomical and physiological peculiarities of the several organs.

In this connection I wish to impress upon your minds

the fact that not only aconite but each and every drug possesses a certain individual, definite general effect that when once ascertained may be traced through all the organs in the artificially diseased body, and that the variations are those peculiar to the structure and functions of each of these organs.

We will now proceed to review in detail the individual conduct of the different organs under the stimulus of the exaggerated circulation.

* * * * * * * *

BELLADONNA. To-day your attention will be directed to the pathogenic effect of this drug for the reason that its toxic influence continues the diseased process caused by aconite. The circulatory storm is even more violent than that of aconite, and there is also besides an actual capillary stasis, passing into fully developed local inflammation attended by all its typical changes and morbid products. This inflammatory state localizes itself in some organ or organs and pursues a definite character and course.

The whole integument of the prover becomes darkly and uniformly reddened, inflamed, dry and burning hot to the touch and is associated with a high temperature, violently throbbing arteries, intense thirst, dryness of the mouth and fauces which are scarlet in color and greatly swollen, twitching of the muscles, convulsions and delirium more or less violent. *The inflammation caused by belladonna is always active in character and acute in its onset; is uncomplicated with degenerative changes of structure; pursues a definite course from first to last, and yields the products of simple inflammation only.*

Belladonna is therefore especially adapted to those acute disorders in the nomenclature of which the word *itis* occurs as a suffix. Beside this tendency to develop active inflammation, like other drugs, it also has the property of selecting certain tissues and organs and impressing these more violently than others. Therefore belladonna is seen to exert a preference for the brain, its membranes and its nerves, and causing profound disturbance in the functions

of that organ. So constant is this disposition that whatever part of the body is deranged by this drug these three elements are always found to be present, viz.: intense local congestion, local inflammation and cerebral involvement.

The details of these morbid conditions will receive their proper attention when we come to consider the special organs in which their manifestations take place. Belladonna is a powerful convulsant and both varieties of spasm, clonic and tonic, are embraced within its pathogenic influence. The former kind is too well known to need extended mention, but the latter may be less familiar to you, although it is generally distributed throughout the body.

Thus we find it occurring in the masseter muscles where it constitutes trismus; in the facial muscles producing risus; in the pharyngeal muscles causing actual constriction and dysphasia; in hollow or organs such as the stomach, intestines, bladder, uterus, canals and ducts, in all of which the tonic spasm of belladonna occurs suddenly, clutches tightly, lasts a longer or shorter time and quickly relaxes, thus affording an explanation of the symptom: "The pains come on suddenly, are severe, continue for a time and cease as suddenly as they commenced."

The bearing down pains in the region of the uterus, as well as the tenesmic pains produced in the sphincters of the rectum and the bladder, are also caused by the same kind of local tonic spasm.

* * * * * * * *

MERCURIUS. A study of the effects of this potent drug upon the human economy carries us a step farther in the production of artificial disease, viz.: that of degeneration in ultimate structure, a slow decay in the elements of all the organs in the body resulting in the gradual destruction of the latter.

It has been aptly said that "history is mainly the record of individual and collective murder," and the pathogenesy of mercury has accumulated in pretty much the

same way. Our knowledge of its morbid scope has chiefly been obtained through the sufferings and untimely death of those unfortunates who have sustained the toxic effects of mercury, either by its medicinal or industrial use. The blighted bodies, wrecked constitutions and wretched lives contributing to this grand total of evil consequences, greatly outnumber the victims of all the cruel epidemics.

Mercury is classed by the dominant school as an *alterative*, and although this term is an ambiguous one in a therapeutic sense, yet in the present instance it is correctly applied, for this metal either pure or combined in various salts has the property of so transforming the entire assemblage of healthy cells and tissues that Nature would scarce recognize them for her own. The cell contents are so deficient in vitality that they soon undergo physical and chemical changes and become necrosed. The lymphatic glands that are concerned in the manufacture of these cells are themselves subject to the same morbid changes. I have dwelt upon this state of affairs as I wish to impress you with the knowledge that *a peculiar and general cachexia is stamped upon the composition and activity of the cell contents throughout the entire body.*

The natural secretions and excretions are, to use a paradox, unnatural, for without exception they are altered in color, appearance and chemical composition; they are always putrid and so acrid that they excoriate and inflame the skin over which they pass. The inflammation instituted by mercury, whether in skin, mucous membrane, connective, interstitial or glandular tissues, invariably tends to their destruction, sometimes suppurative, sometimes ulcerative, occasionally phagadenic. This inflammation is not active in its nature, but is sluggish in progress, and ends in the establishment of either of the foregoing processes. Pus, formed under these circumstances, is thin in consistence, dirty yellow or greenish yellow in color, more or less putrid, and aften streaked with thin uncoagulable blood. After an abscess has formed and discharged its contents in the natural manner,

or by the use of a lancet, there is no tendency toward healing, and destructive suppuration continues without limit. When ulceration takes place it does not extend deeply, but instead it spreads laterally in all directions with irregular zigzag borders, has a base resembling lard or bacon and bleeds at the slightest touch.

Mucous membranes wherever existing experience a low grade of catarrhal inflammation and pour out a vitiated mucus or muco-pus possessing the same acrid character of the other fluids influenced by the same general cause. At the same time these mucous membranes are swollen, spongy, bleed easily, and become eroded or ulcerated. The surface of mucous membranes becomes eroded and exudes lymph, forming false membranes which undergo decomposition and slough. The skin is especially prone to ulceration, eruptions soon become pustular or the excoriated surface pours out a putrid discharge. All parts of the body become infiltrated with serum to a certain extent inducing a flabby, bloated appearance, while a dropsical state often masks extreme emaciation. Profound asthenia is invariably present, the muscles waste, and arthritic and bone pains occur nightly. The subject of mercurialization is very sensitive to changes in the atmosphere, particularly so in damp or wet weather when all symptoms become aggravated. An oppostie state of affairs also develops, in which various pains are increased by warmth of the bed and although the person sweats easily and profusely and almost continuously no relief follows; this diaphoresis is due to excessive asthenia and is not in the nature of a crisis.

There is no crisis in the effect of mercury, but instead there is instituted a continuous molecular destruction of tissues and organs, going on from month to month.

We will now consider this general cachectic state as it is seen to present itself in different organs and observe how function and structure are modified in each of them by the prevailing pathogenic cause.

* * * * * * * *

GUNSHOT WOUNDS AND THEIR TREATMENT.

BY HOWARD R. CHISLETT, M. D., PROFESSOR OF THE PRINCIPLES AND PRACTICE OF SURGERY IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL, CHICAGO.

PART II.

In this part of our subject it is our purpose to take up gunshot wounds of special regions.

The head. Shot wounds of the head may be penetrating or non penetrating. The wounds of the soft parts, as laceration of the scalp or of the face, do not demand special consideration except the necessity for perfect cleanliness and accurate apposition of the wounded surfaces to limit the amount of deformity. In the more extensive injuries we may have one or more of the tables of the skull fractured. If only one plate is injured, it is usually the inner one, and this condition can only be diagnosed by the symptoms of cerebral compression. Most frequently both plates are involved and considerably splintered, the ball passing usually into the brain substance and carrying some of the detached splinters with it for a greater or less distance. Thus the amount of comminution of the bone is a comparative index to the amount of laceration of the brain tissue. The dangers are early death either from shock or hæmorrhage, and inflammation and its results.

Treatment. Keeping in mind that the chief danger aside from the shock and hæmorrhage is the danger of inflammation, the necessity of most stringent measures of cleanliness and sterilization in dealing with these wounds will be appreciated. These preparations should be carried out in the minutest detail even for an examination, and this particularly where the wound is known to be penetrating. Brain symptoms, threatened or present, are best controlled by the ice cap. Never probe a penetrating wound of the cranium. If you have a comminuted fracture of both bones or a depressed inner table, the indications are for enlarging the opening, elevating the depressed fragments which are attached and removing those splintered fragments that are separated. Any other foreign bodies that may have gained entrance and can be readily detected should also be removed. The removal of a ball from the brain substance, unless it can be seen or easily felt, should never be attempted as a primary operation. If, later, the symptoms it produces will indicate positively its location, its removal

may be attempted with far less danger. In cerebral compression, after a gunshot injury of the head, trephining is indicated, whether that compression results from a compound, comminuted fracture, from a depressed inner table, a blood clot, or from pus formation. Hæmorrhage may be arrested by suture or lateral ligation if one of the sinuses be opened, and by antiseptic tampon if a general oozing. Abscesses must, of course, be drained. When the face is extensively injured the greatest dangers are hæmorrhage, section of the branches of the facial nerve and disfigurement either from paralysis or cicatricial contractions. It is perfectly astonishing the extent to which the tissues of the face can be injured and still live. Even in extensive lacerations and in tissues so devitalized that you would remove them in localities other than the face, repair will take place with little deformity providing the parts be maintained aseptic. If the tissues are very badly traumatized, it is my own practice not to perform immediate suture but to dress the wound with moist antiseptic dressings and to wait for twenty-four or even forty-eight hours, thus giving the tissues an opportunity to re-act without the damaging effects from the tension of sutures. When the circulation in these parts has become established, which it will do in this length of time if at all, the parts can be more accurately sutured and with a better prospect of primary union. I have found either fine silk or horse hair the best suture material for facial wounds. The bones of the face may be pronouncedly comminuted and still retain their vitality. Only those fragments that are hopelessly detached should be removed, the others being moulded into as nearly as possible their normal position.

Neck. Shot wounds of the neck are very serious on account of the important structures in that region. The wounds of the large vessels are frequently fatal before help can be secured. Unless first examination satisfies you positively that important vessels and nerves are uninjured and that there are no wounds of either œsophagus or larynx, careful exploration of the wound is justifiable. Vessels should be ligated, divided nerves united by suture, rents in the œsophagus repaired, and if the larynx be involved a tracheotomy performed. The wound should then be packed with iodoformized gauze, no attempt being made to suture until satisfied that the danger of suppuration has passed. If necessary to prevent retraction of the lips of the wound a few temporary sutures may be inserted

through the skin, but the danger of suppuration in the deep connective tissue planes of the neck is so great that my own preference is the use of the antiseptic tampon with subsequent suture.

The thorax. Non-penetrating wounds of the chest demand the same treatment as in other soft tissues unless fractured ribs complicate the case. Should the ribs be fractured, comminuted fragments should be removed, saving the periosteum if possible. This part of the thorax should then be immobilized in so far as it can be by means of broad adhesive straps leaving a sufficient space over the wounded rib for open dressing. Penetrating wounds are especially serious if the heart or lungs be involved. Shot wounds of the heart are usually fatal though it is possible a bullet may become lodged either in the heart muscle or the pericardium and require removal. Death results usually from hæmorrhage into the pericardium, causing mechanical compression of the heart. Wounds of the lung, though not necessarily fatal, are commonly so from shock, from hæmorrhage or from secondary inflammations such as pneumonia or pleurisy or their combination. The characteristic signs of lung injury are: Severe shock; cough, with bloody expectoration; hæmorrhage from the wound, the blood being frothy from admixture with air; difficult and painful respiration and compression of the lung from hæmorrhage into the pleura. The prognosis should be always grave, though it will depend not only upon the severity of the injury but upon the time at which the patient applies for treatment and whether or not the wound has become infected. I have had several cases in the last few years of undoubted wound of the lung that have recovered.

Treatment. The first indication is for the control of serious hæmorrhage. The arrest of external hæmorrhage either from the intercostal or the internal mammary arteries is not difficult, although at times section of a costal cartilage will be found necessary to secure a retracted internal mammary. All injured vessels should of course be ligated. Severe hæmorrhage from lung wounds is very uncommon unless one of the large thoracic vessels be injured. In such an event the case will prove rapidly fatal. The hæmorrhage from the lung tissue is, as I said before, seldom great and where the penetrating wound is small will usually cease spontaneously with absolute rest in an inclined position. Where the wound of entrance is large

and the damage to the lung extensive, it may seem best to insert a tampon of iodoform gauze. Otherwise the wound of entrance should be sealed with an iodoform collodion dressing, if no foreign bodies other than the ball have gained entrance. Extensive hæmorrhage into the pleura causing compression of the lung had better be removed by section of a rib and drainage, rather than by aspiration, because the blood usually coagulates and would be imperfectly removed by the latter method. Antiseptic drainage also will prove the best preventive, of subsequent empyæma. Should hernia of the lung appear, reduce it as soon as possible, enlarging the opening if necessary. If strangulation of the protruded portion has already taken place it is best removed by means of the actual cautery, which will obliterate the severed air cells.

Penetrating wounds of joints. These wounds are very serious, entailing, as they often do, ankylosis if not loss of limb. Such wounds are commonly associated with fractures of one or all of the bones entering into the joint formation, and the prognosis will depend largely upon the condition of the bones and the presence of foreign bodies other than the ball.

Treatment. If the surrounding injuries are slight, if foreign bodies other than the ball have not gained entrance, if the wound has not been probed, thoroughly cleanse the part and the surroundings, seal the wound with a collodion dressing, place the limb at absolute rest on a splint and apply ice bags to prevent inflammation. When the surrounding structures are extensively destroyed, if the wound is large and the escape of synovial fluid pronounced, or foreign bodies other than the ball have gained entrance, the joint cavity should be freely opened, all tissue which is damaged beyond hope of recovery removed, the parts moulded into as nearly as possible their normal shape (retaining them so, if necessary, by means of sutures), the joint thoroughly sterilized by antiseptic irrigation, adequate drainage supplied, the part enveloped in abundant antiseptic dressing and maintained at perfect rest by means of splints. When, in addition to such extensive injuries, the main arteries and nerves are injured, amputation well above the injured parts should be the only method considered.

The abdomen. Shot wounds of the abdomen are attended with more shock than those of any other part of the body. This is a general proposition, and, as a rule, the

shock is proportionate to the extent of injury. The mental condition of the patient, however, at the time of its reception influences the shock so much that we may have even slight contusions of the abdominal walls with a fatal termination, and extensive lacerations with multiple perforations without any, or with very slight shock. As in all other cavities of the body, wounds of the abdomen may be penetrating and non-penetrating. The surgeon's first duty after attending to the urgent symptoms of shock is to determine which variety he has to deal with.

If we take into consideration the size of the ball, the distance and direction from which it came, the position of the patient at the time of accident, the plane at which the ball strikes the body, and the thickness of the abdominal wall, together with the extent of its protection by the clothing this differentiation can usually be made without exploration. In all cases of doubt, where the course of the ball is so irregular that the probe will not follow, the tract should be exposed by careful dissection with the scalpel sufficiently far to satify you whether the abdominal cavity has or has not been invaded. If the wound is non-penetrating it should be treated as any ordinary flesh wound. Penetrating wounds are of course far more serious, and will in most instances demand immediate laparotomy. The two pressing indications for abdominal section are severe internal hæmorrhage and perforation of the gastro-intestinal canal. Serious hæmorrhage usually arises from injury to the solid viscera such as the liver, spleen and kidneys. The location of the injury and the well known signs of excessive hæmorrhage will assist you markedly in the diagnosis. The patient should be placed in a room of about 80 degrees F. and a median incision made. The location of the shot wound must decide whether the incision should be above or below the umbilicus. It must be made quickly and with no other hesitation than to render the field aseptic. After the peritoneal cavity is opened the bleeding may be so profuse as to obscure the points from which it comes. Digital compression of the aorta immediately below the diaphragm will temporarily arrest the hæmorrhage while you conduct your examination. If the wound is of the liver, and is a deep one, bleeding is best controlled by packing with iodoform gauze, the ends of which should be brought out of the abdominal wound or from a separate incision over the location of the injury. Superficial wounds of the liver may be controlled by suture. In lacerations of

the kidney where compression from packing is inadequate, nephrectomy is indicated. If packing is sufficient to arrest renal hæmorrhage, and particularly if the pelvis of the kidney or the ureter be wounded, a separate incision should be made through the loin and the end of the gauze packing brought out through that incision. After this the peritoneum over the kidney can be carefully cleansed and sutured, thus protecting the abdominal cavity from contamination with urine. Laceration of the spleen will demand its removal in case the antiseptic tampon fails to arrest the hæmorrhage. Multiple punctures of the mesentery can be closed and the hæmorrhage arrested by sutures.

Except the escape of intestinal contents we have no absolute proof of intestinal perforation before operation. The inflation of the intestinal tract with hydrogen or other gases is not of practical application in most cases. In all penetrating wounds of the abdomen the whole of the intestinal tract should be hastily, though carefully, examined, and this is particularly important if the wound of entrance be at the level of or below the umbilicus. Below the umbilicus either transverse or antero-posterior wounds usually cause multiple perforations. Above this level we are more likely to have either simple perforation or possibly none at all. There is no doubt that the length of time consumed in these operations has greatly to do with the high rate of mortality, and though thoroughness should never be sacrificed to speed, the examination should be *systematic*, so that time may not be wasted. Beginning then at a given point, say for instance the ileo-cæcal valve, the whole of the intestinal tract should be gone over inch by inch, *without at any time exposing more than a few inches of intestine to atmospheric influence*. Each perforation should be sutured by the method of Lembert or Glover suture, of fine silk or cat-gut, without taking the time to trim the margins. Flushing of the abdomen should be reserved for those cases in which there has been an extravasation of intestinal contents. This will apply equally well for the necessity for drainage. Where multiple perforations are found in a coil of intestine, represented by a few inches or even a foot, particularly if the openings are large, resection of this portion of the intestine with end to end union by means of a Murphy button could be more quickly and safely performed than suture of the perforations, with its dangers of constriction and paralysis.

After treatment. The patient should be put to bed as

soon as possible and the bodily warmth maintained by external applications of heat. If the stomach has been wounded the patient should be nourished by nutrient enemata for the first forty-eight hours, after which liquid foods may be administered. Perfect quiet should be maintained, even if opiates are necessary to attain this end. After the effects of the chloroform have passed away the patient should have plenty of water and liquid foods in small quantities. At the end of the first week easily digested or pre-digested solid foods may be administered. If everything progresses favorably no attempt need be made to move the bowels until the fifth or sixth day, but should signs of peritonitis develop, a good saline cathartic should be at once administered.

CLINICAL CHIPS.—Dr. E. P. Clapp recommends tarentula as an internal remedy for the burning pain of a carbuncle.——Neurasthenia has been defined as "a hysterical compound of contradictions."——A very clever correspondent has cured an inveterate nausea with a furred tongue and frothing of the saliva by giving the patient hard cider to drink.——One should be careful not to compound cyclical albuminuria with the albuminuria that is caused by riding a wheel.——Dr. Roswell Park advises to rub and scrub the hands with a mixture of green, or other soap, corn meal and mustard flour for about five minutes, with and without a nailbrush, as a means of rendering them thoroughly aseptic. This is also a thoroughly deodorizing mixture for the removal of offensive odors from dead and dying tissues and from iodoform. ——Tampons of cotton soaked in pure glycerine are almost specific for chronic rhinitis and chronic coryza.——Dr. J. P. Rand, of Worcester, Mass., holds that many, perhaps most cases of biliary colic are due to tight lacing, and desires correspondence on the subject.

Clinical Society Transactions.

CORNELIA S. STETTLER, M. D., Corresponding Secretary.
ORRIN L. SMITH, M. D., Recording Secretary.

NOVEMBER MEETING, 1897.

The regular monthly meeting of the society was held in the Hahnemann College amphitheatre, November 27, at 8:30 P. M., Vice President Leavitt in the chair.

REPORT OF THE SECTION ON OBSTETRICS AND THE PUERPERAL DISEASES.

SARAH HOBSON, M. D., Chairman.

LX. False prophecy in obstetrics. By Dr. Cornelia S. Stettler.—For our present purpose married women may be divided into two classes: (1) Those who do not wish to become mothers, and (2) those who do.

These two classes are very differently affected by the dictum of a doctor who says it is impossible for them to become pregnant. In the first case, if the woman, believing that the doctor knows it all, takes no precaution against it, finds that he was mistaken, she will always question his honesty and his ability as an obstetrician, as well as a general practitioner.

When, however, a married woman who is anxious for progeny is told by her medical adviser that she cannot be blessed in that way, the verdict is cruel and unwarranted in proportion as it is bluntly told, or is reached upon insufficient evidence.

There are various reasons to account for mistaken judgment in such cases. Sometimes the patient is thought to be too old, too ill, too fat or too lean for conception to occur. Again, such an opinion may be based upon the existence of a chronic inflammation, displacement or discharge which is thought to be sufficient to cause sterility. The same prediction has been wrongly made in cases of insanity, incompatibility, epilepsy, hystero-epilepsy,

fibroids and other tumors, relapsing peritonitis, specific lesions of the appendages, menorrhagia, dyspareunia, etc.

In consequence of these misfit prophecies a great amount of unnecessary suffering has been engendered; for to deny a woman whose hopes of happiness centre in the possibility of her ever becoming a mother is to sentence her to the sorest disappointment of her life. Considering the readiness of many physicians to pass such a sentence without due consideration of the facts in the case, or of the feelings of the party most intimately concerned therein, this is a very serious matter. We believe that this brutal habit should be broken up, for in truth no one can tell what may happen in such a case, and no one is ever justified in taking such a position without some qualification.

Many a pregnant woman is made wretched because she has been told that she could not possibly go to term, and the more anxious she is to become a mother the worse she will feel about it. She may have miscarried once or more already, and from something connected therewith, or for some fancied reason the doctor may decide in his own mind that the same experience will be repeated indefinitely, and so he prophecies only evil for her and that continually. No allowance is made for changed conditions as time goes on, or for her being placed under proper hygienic and homœopathic treatment. It does not follow that the habit of aborting is incurable in any case. Because an echo of this sort has repeated itself several times, we should not insist upon its perpetuity, but give the patient the benefit of hope, and time and skill, and then trust to Providence for a happy outcome.

A more aggravated form of false alarm in obstetrics has its root in the habit of deciding beforehand that a safe termination of labor in a given case is impossible for the child and probably also for the mother. This kind of an opinion is usually predicated upon an experience which the patient and the doctor have had before, in which case the doctor is tempted to take a cruel experience as a criterion of what must always follow with the same patient.

We all know that this kind of reasoning is fallacious, for nothing is more common than for women who have had a terrible time with their first labors and lost their children, to go through nicely and safely with subsequent confinements. It would be quite as reasonable to say that because Mrs. Jones had such a fearful time when her baby was born, therefore her next door neighbor, Mrs. Smith, would certainly do likewise. Such a spirit of evil prophecy savors of the dark ages in midwifery. We may fear such a result and should be prepared for any possible complication or emergency, but the case would be a very exceptional one in which a doctor would be warranted in giving expression to such an opinion, especially to the patient herself, or to any other woman in the neighborhood.

There are traditions among women who are likely to become mothers which sometimes puts them in great dread of the puerperal possibilities. Perhaps they have heard or known something of the diseases of the lying-in and of the terrible scourge of what used to be called "childbed fever," from which so many thousand women have died in former times. Their neighbors and friends may hold this experience in as much dread as a fond mother has lest scarlet fever or diphtheria should come into her family. This subject may have been discussed or dwelt upon during the long weeks of pregnancy until the cloud in her horizon is of the most threatening kind.

Thus, there are women who make no account of the discomforts of gestation, and the pains and the woes of parturition, but who have a mortal dread of the sequelæ that may follow within the first month after their delivery. It is a cruel thing, therefore, to foster such apprehensions or to plant the seed of discouragement in the minds of such patients. If the doctor is a pessimist he should be banished from the bedside of such a patient, for, while strict asepsis might save her life, no moral antiseptic would keep him from being mischievous in such a relation.

In many cases this dread of puerperality is heightened by an unfortunate experience connected with a former

labor. One who has had some kind of puerperal inflammation, peritonitis, metritis, ovaritis, with or without suppuration, or phlegmasia alba dolens, will have a natural dread of repeating that experience. Unpromising as such cases sometimes are, it does not follow that the same mishap or anything like it will occur again. I have recently had an experience of this kind which illustrates this point:

Three years ago with her second child my patient suffered severely and almost died under the care of an excellent physician from a terrible attack of lymphangitis and phlebitis. She finally recovered after six months of suffering. Within another year she became pregnant again and everybody concerned, and she most of all, was in dread of a repetition of her former experience. She suffered so severely throughout this third pregnancy and was in such constant fear of a puerperal calamity that it came to be a serious question whether a premature delivery should not be induced. After a formal consultation, my advice to try a more conservative method, to await developments, to inspire a hope of escape and to give her the proper homœopathic remedies, was adopted. She went to full term and I had the pleasure of carrying her through her delivery and puerperality without any serious consequences whatever.

It would be an easy matter to cite other cases from one's experience in confirmation of the suffering invoked through a wrong obstetric prognosis. They will probably be brought out in the discussion. Those who practice the habit of guessing about these matters and assuming to foretell with a show of certainty what is going to happen, really know but very little about it. If some of these cases were not so thoroughly charged with serious possibilities the revelation of the final outcome would be ridiculous.

Briefly, therefore, we are led to submit the following propositions: (1) Whether a woman desires to have children or not, it is wrong for the physician to tell her that such a result is impossible. (2) Nature has thrown such safeguards about the fœtus in utero and has so many resources which tend to its safety, that the most unpromis-

ing cases will often be carried to term, especially if we do not discourage the patient beforehand, or despair of a good result ourselves. (3) Since premature delivery, the Cæsarean section, Porro's operation and symphysiotomy under anæsthesia have taken the place of the horrible old obstetric operations that murdered the child and mutilated the mother, the doctor and the nurse, and everybody who is interested in a pregnant woman, should cheerfully and joyfully encourage her to hope for a safe and speedy delivery when the time arrives. (4) An intelligent patient can be made to understand that the resources of aseptic midwifery are almost always sufficient to ward off the threatened dangers of the lying-in. The statistics that will prove most conclusively the remarkable exemption from puerperal disorders under the newer methods of treatment as compared with the old are available and should be familiar to all who engage in the practice of obstetrics. These facts should not only keep the doctors from prophesying evil for their patients, but should dispel the fear and the apprehension of the patient herself.

Discussion: Dr. Leavitt: I am very glad that Dr. Stettler has given us this excellent paper on the propensity of physicians to make unfavorable prognoses concerning the possibility of pregnancy, the outcome of pregnancy and the results of labor. I myself have often felt tempted to offer just such a public rebuke to these pessimists. I have run across many women who related predictions of this nature, but I have always regarded such predictions as ludicrously absurd, since we can never know in advance what wonderful evolutions Nature is capable of affecting in order to conserve the best interests of humanity.

I was especially impressed by what the essayist had to say concerning the unfavorable prognoses often made with respect to the outcome of labor. The fact is that we still have a very imperfect knowledge of the dynamics of parturition, though much study has been devoted to them. We do not know that dystocia will be developed in a second

or third labor because it has characterized one or more former deliveries. In the absence of some mechanical obstacle to delivery through the natural passage we best show discretion by reserving our opinion of the character of a labor which may follow. The unwisdom of a contrary course has been accentuated to me within the past few days. A woman had two labors which were terminated by craniotomy. At the third delivery, some three or four years ago, I was called in consultation, and after a strenuous but unavailing effort with the forceps, I performed symphysiotomy and delivered a living child. That child is still living.

The woman was delivered a fourth time, about two years ago, by another physician, version being performed and a dead child being the result. A few days ago the husband called to inform me that his wife was ready to be confined a fifth time, and at my suggestion she was removed to the Hahnemann Hospital. Labor pains set in earnestly about 4:30 P. M. and about 11:30 the same evening I applied the forceps and delivered a second living child of a size which equaled that of the other fœtuses. In this instance I truly believe that labor would have terminated in a natural manner had I given it sufficient time.

Such experiences as these teach us to beware of prophecies which may prove to be devoid of the right kind of inspiration and make us the laughing stock of our brother and sister practitioners.

Dr. F. H. HONBERGER: The paper presented by Dr. Stettler is a most excellent one. I cannot but emphasize what she has already said. Patients frequently come to us saying they have missed one or two menstrual periods; they are in a dreadful state of mind, and perhaps very much frightened from having been told at some former time that should they become pregnant again they could certainly not live through another confinement. They come requesting us to produce an abortion; feel hurt that we refuse and seek some other physician, perhaps, not feeling safe; assure them as much as we will that they are

all right; that there is no reason for their fears. A short time ago I had one of those cases. She had three doctors and a dreadful time at a previous confinement. They all told her that she could not live through another labor. I assured her that her fears were groundless, and as is frequently the case, when the time came she had a short, easy and absolutely normal delivery and recovery.

There is another class of cases that come to us, viz.: those who do not want to become mothers. They will, perhaps, falsely tell the same story and resort to almost anything to have an abortion produced, if one would listen to them. This should never be done except as the doctor has said, where there is actual severe pelvic osseous deformity.

Dr. CHISLETT: I really cannot see, Mr. President, that there is much to add to Dr. Stettler's paper. The conclusions are logical and I heartily commend them. The practice of making an unfavorable prognosis for women in their periods of gestation is pernicious. As a form of therapeutic suggestion it should be strongly condemned. I can recall one case, however, which occurred several years ago, which made me wish that somebody had made a bad prognosis for and that somebody was a powerful enough hypnotist to prevent further conception by suggestion. The patient was a woman of good health, young, and had been remarkably well through the period of gestation. During the early hours of this, her first labor, the progress was natural and when I first saw her the dilatation was progressing nicely. The head finally presented at the vulva and there it remained, although the expulsive efforts were strong and continuous. The head was finally delivered with the aid of forceps, but still the baby would not come. By passing the fingers well up along the neck of the child and then along its anterior surface I could feel a large tumor which apparently caused the difficulty. It was too high up to attempt its displacement, so I forcibly removed the child by traction on the head and later upon the shoulders. The tumor was composed of the abdomi-

nal viscera and heart protruding through an imperfectly formed anterior abdominal and thoracic wall. The viscera, stomach, liver and intestines were imperfectly covered by a thin membrane which may have been complete but torn in the delivery. The little heart was completely in the world and was beating at the rate of 160 to the minute when the child was born. I watched the child, as soon as the mother was cared for, until its death thirty minutes later. The last minute the heart beat just twice. I brought the child's body home and showed it to two or three of our physicians but there was such opposition by the father to my having it that it was thought best to destroy it.

Dr. HOBSON cited two cases of false prophecy; one a case of lacerated cervix in which the prognosis was made that pregnancy would be impossible in presence of so extensive a lesion. But before the arrangements for repair were perfected the patient found herself pregnant. The termination was a normal easy labor at full term. The second was a case in which pelvic measurements had been made with the diagnosis of contracted pelvis to such a degree that natural delivery would be impossible. Nevertheless conception occurred and the woman was delivered at full term without instruments.

I heartily concur in the opinion that it is refined cruelty to tell a wife she probably cannot bear children, so long as she desires offspring and there is a possibility of the occurrence of pregnancy. In the most untoward case, the passing of the years and a woman's own mental processes will reveal the inevitable outcome far more kindly than the doctor's dictum.

Dr. R. LUDLAM: It is as pleasant as it is rare to find a topic in obstetrics that has not been thrashed to pieces already. I cannot recall a single essay or monograph upon this special subject. Indeed, the matter of obstetric prognosis has been very much neglected, not only in our colleges and in our literature, but also by the profession at large. What we have in that line is not modern but

ancient history; for, while extraordinary attention is being given to the etiology of disease and to the newer technique of medicine and surgery, prognosis is a lost art, or nearly so.

The extension of surgical methods to the management of pregnancy, parturition and puerperality indicates a wonderful progress in averting disease and in saving human life. Almost everybody is satisfied of this fact, and the time is coming when it will be regarded as criminal not to avail ourselves of these proper and necessary safeguards. But, strange to say, the prognostic hints and helps that we have in midwifery are based on the tradition and experience of præ-aseptic times. The medical Jeremiahs to whom the essayist has so cleverly referred, still continue to prophesy evil because evil results so often followed the obstetric practice of their forefathers. Their predictions are not tuned to the aseptic key, or they could not be so dismal and so discouraging for the woman who is in the way of becoming a mother.

There is force in what the doctor says of the modern obstetric resources that were unknown, or but half known, twenty years ago. When this Society was formed nobody had ever made an aseptic Cæsarean section, Porro's operation had not been dreamed of, nor had symphysiotomy or curettement been rediscovered and applied under new and safe conditions. It is impossible to adjust the old, scarecrow prognosis to the newer and more scientific methods of practice.

There is force, too, in Dr. Honberger's charge that the habit of evil prophecy in obstetrics fosters and encourages the abominable practice of willful abortion. The forebodings of those who deal in that horrible business, and who frighten the poor women into believing them to be true and well founded, are intended to deceive the mother and to destroy the child. Indirectly they result in the murder of thousands of little innocents every year. I assure you that in the review of my professional life nothing gives me greater pleasure than to think that a score or two of young men and women, who are a blessing to their families, and

who are moving in good circles to-night, owe their lives to my strenuous warfare with the dismal predictions of those who, before those people were born, were lying in wait for their lives.

Dr. C. S. Stettler: In closing the discussion upon my paper I have nothing further to add except to say that from my professional experience, as well as from my social observation before I became a physician, the subject seemed to be a practical one and deserving of consideration by the Society. I am thankful for the endorsement by the members present, and for their very kind appreciation of my paper.

LXI. Upon the selection of remedies during the puerperal state, with especial reference to cinchona. By Dr. G. Hardy Clark.—It will be impossible, in the few minutes allotted to me this evening, to give a connected account of the many remedies used during the progress of labor and the conditions immediately following its completion. I am too greatly opposed to giving drugs because they are "good for" the parturient woman to advise their use in a general way, so I am forced to elucidate, as far as is practicable, the use of one drug and the general principle upon which all drugs should be prescribed.

I have selected the drug cinchona to illustrate my subject because its application to the puerperal state is just now attracting considerable attention, because its many years of successful use give it more than transient interest, and because some of the more recently discovered effects of the drug have never been affiliated to its action in this field.

Nothing but the great law laid down by Hahnemann can be used to explain the wonderful analogies which exist between the toxic symptoms of this drug and its use in medicine. The simple recital of the conditions for which cinchona is useful would have only the value of the arbitrary dicta of the old school of medicine. To have a last-

ing value it must be shown that a natural law is here in operation, explaining, simplifying and making logical its action.

It will be necessary to prove that if cinchona has a corrective effect upon any of the abnormal phenomena incident to labor it will, if taken by a healthy person in poisonous doses, direct its energies toward the production of similar phenomena.

I will first point out the relationship existing between the toxic effect of cinchona and delayed labor.

In large doses the drug produces general muscular debility. The muscles feel bruised and there is a general sense of malaise and relaxation. The heart action becomes weak, the arteries lose tone, the pulse becomes rapid and small and the face pale and bloated.

This action of the drug is acknowledged by all writers upon the subject, and it is passing strange that these same writers fail to acknowledge the similarity between the action of the drug and the atonic state of the parturient for whom they prescribe it.

This drug is of vast service as a uterine tonic because the uterus is a muscular organ, and is affected in common with the muscles of the heart, arteries and muscular system generally. When cinchona is indicated in this class of cases the woman has come to the lying-in chamber handicapped by debility, subject to some dyscrasia, or meets with the misfortune of exhausting obstacles to normal labor, or an excessive hæmorrhage will have robbed the uterus of its tone. The patient's face will be pale, the heart's action weak; there will be a sense of muscular debility and malaise.

Cinchona can under no normal circumstances initiate uterine contraction, and has no function to perform when labor is delayed by irrational muscular action or by mechanical obstruction. When the general physical conditions call for it cinchona will not disappoint you in threatened abortion, but its field of usefulness does not in

any manner encroach upon the territory occupied by actea racemosa, aurum and other drugs.

Another condition for which we prescribe cinchona with excellent effect is hæmorrhage. Here again the prescriber must satisfy himself that he is applying the drug in strict accord with the conditions present, and that these conditions are similar to those induced by the poisonous effects of his remedy. We must first turn to the toxic effects of the drug to get our bearings. We have here the relaxed arteries previously noted, and the additional very significant fact that the venous capillaries are invariably engorged with blood. This condition alone sufficiently threatens hæmorrhage, but when we add to it the well-known fact that the drug markedly lessens the coagulability of the blood, and actually induces hæmorrhages from such organs as the lungs and kidneys, we have a perfect picture of drug action to fit to ante- and post-partum hæmorrhages.

In prescribing cinchona for hæmorrhage it has always been the custom of physicians to exclude the cases dependent upon placenta prævia, rapid delivery, retention of secundines, injury to the cervix, vaginal canal and vulva, etc., etc., and to confine its use to cases where the atony of the uterus is shared by the muscular system generally, where there is present a tendency to local venous stasis from lack of tone of the arterial system, and where exhaustion from protracted labor or from disease predisposes to hæmorrhage.

The third state to which I invite your attention is the pernicious effect of excessive loss of blood, and to the entire homœopathicity of this state to that induced by the drug in the healthy individual.

Cinchona induces but little change in the size and shape of the red corpuscles, but greatly impairs their ability to carry oxygen to the tissues. The relation of the number of white to red corpuscles, however, is greatly changed, in that the white variety is increased sufficiently to approximate the condition found after excessive hæmorrhage.

Keep this fact in mind and observe the startling similarity of the symptoms produced by the drug, and those com monly found after excessive hæmorrhage.

There is present pale face with giddiness, tinnitus aurium, and impaired hearing, sunken eyes, dilatation of the pupils and loss of sight; cold perspiration, trembling of the limbs, muscular relaxation and a weak heart. Compare this condition with the following short selection of symptoms which has guided the homœopathic practitioner for many decades, and which has been of untold service to humanity.

"Uterine hæmorrhage; great pallor; ringing in the ears; fainting; cold; loss of sight; twitches and jerks; wants to be fanned."

"Prostration, even to syncope, which follows puerperal hæmorrhage; sighing; gasping."

"Lassitude, indigestion and weak heart persist after hæmorrhage."

I have tried to indicate in the foreging analysis of the uses we can properly make of cinchona, the plan to be pursued in all prescriptions addressed to the puerperal state. We have to remember that the healthy individual in normal labor requires no therapeutic assistance from drugs. When a remedy is prescribed it should be with a full knowledge of the taints of rheumatism, sepsis, syphilis or other disease which the patient may have, and a knowledge of the state of the heart, vessels and kidneys, as well as a sufficient understanding of drug action to affiliate the proper remedy to the abnormal state.

Discussion: Dr. Honberger: In regard to remedie used during confinement, it is not my habit to depen much upon remedies to assist in delivery. Frequently we are called upon to deliver cases that we have not seen until in actual labor and could not use remedies had we so desired for weeks or months and cannot say that have seen any special benefit from remedies upon cervix during labor. In post-partum hæmorrhage have most frequently used

china, low, with excellent results, not depending entirely upon the remedy alone ; always manipulate the uterus to keep it emptied of all clot and in a state of contraction.

Dr. HELEN M. BUCHANAN : The call for interference during labor being mainly due to some abnormality existing which is only amenable to mechanical manipulation, there are very few remedies which in my opinion are of any avail. During the first hours of labor should it be slow and tedious, if the pains are strong and regularly recurring, yet upon examination the os uteri is found rigid and undilated to any considerable degree, it is my custom to have the patient put in a warm bath, gradually increasing the heat, allowing her to remain fifteen minutes or even half an hour. I am convinced of the good results of this procedure.

While I have used gelsemium often for this condition, I cannot say that I have had any direct results. The remedy that I use oftener than any other during labor is veratrum alb. So often during a severe pain the patient will cry out with cramping pains in the leg ; veratrum will relieve this symptom, as it invariably will the troublesome cramping in the calves of the legs so commonly complained of during the last weeks of pregnancy. I also frequently give it in the nervousness of the early first stage where the pains are nagging and unavailing.

However, I am free to say that I have found very little use for remedies during labor, as the causes which prolong or complicate the physiological process are outside the province of materia medica and are only remedial by mechanical or operative interference.

Dr. SARAH B. DUNCAN : A kind Providence and my own precaution seem to have spared me critical cases. I demand the privilege of having a patient under my care for a certain period before delivery. Hygienic measures and gelsemium serve me best during labor.

Dr. CORNELIA S. STETTLER : I have enjoyed hearing Dr. Clark's paper, and am prepared to endorse what he has said upon the general indications on the use of cin-

chona during and after delivery. If such an analysis was made of certain other remedies in which we all have confidence, our knowledge of their scope and utility would be very much increased. I have a great deal of confidence in the use of gelsemium to expedite labor, and would be very glad if Dr. Clark would take an early occasion to collect what is known of its use under these conditions.

Dr. CHISLETT: While I have enjoyed Dr. Clark's paper and believe he has illustrated the proper way to study our materia medica, it seems to me wrong that some of the physicians with little experience, and particularly the undergraduates, should leave the meeting to-night with the impression that the severe hæmorrhages complicating labor should be treated by medicines alone. There are very few physicians of experience who, with a patient in the condition described by Dr. Clark, so typical of serious loss of blood, would have the courage to administer china or any other remedy and wait for the results. A patient who has reached that stage of depletion, indicated by the cold, clammy skin, the pale dry mucous membrane, the pinched, anxious expression, the extreme restlessness and thirst, the ringing in the ears and deafness, demands immediate relief. From the standpoint of the surgeon this relief is best obtained by a pint or a pint and one-half of hot normal salt solution administered either intra-venously or into the subcutaneous connective tissue. While I have not done any obstetric practice for a number of years, the only two special conditions during labor which I could think might call for remedies are, a rigid os and hæmorrhage. The homœopathic remedies in both of these conditions were to me entirely unsatisfactory. In my experience the indicated remedies for a rigid os are hot water injections and chloroform inhalation; the only reliable hemostatic, the antiseptic tampon.

Dr. CLARK: In my brief paper I did not propose that china should be used in extreme cases singly and alone, but only as an adjuvant. The practice of obstetrics, like

that of general medicine, should draw largely upon our fund of common sense and experience.

LXII. LABOR COMPLICATED BY A DOUBLE VAGINA AND CERVIX UTERI. BY DR. F. H. HONBERGER.—*Case.* Mrs. C., primipara, a strong, hearty woman about thirty-two years of age, has always enjoyed the best of health; even during the period of gestation she was not disturbed by the many little ailments complained of by most women to a greater or less degree.

The first symptom of labor coming on that she discovered was a rupture of the sac and a discharge of the waters or liquor amnii. Uterine contractions came on immediately with regularity, and quite frequent, not more than two or three minutes intervening between them. A vaginal examination was made about one hour after beginning of labor; the cervix was patulous, but with little or no dilatation. Everything appeared perfectly normal, with a vertex presenting. Labor was allowed to continue some four hours, when another examination revealed the cervix dilated to about the size of a silver dime; the contractions still continued almost without interruption and quite severe; everything else appearing normal, labor was allowed to progress another two hours when, upon examination, the cervix was found dilated to about the size of a quarter, and quite soft. Continuing the examination during a contraction of the uterus with two fingers well up to the os, my attention was attracted by a peculiar contour of the cervical opening; it seemed rather flattened upon one side. After allowing the patient to rest a few minutes, I again crowded two fingers well up into the vagina during a partial relaxation of the uterus, and found that I could hook my fingers over what seemed to be a thick bundle of fibres dividing the cervix; this led to a careful examination of the vagina, which disclosed an antero-posterior septum, beginning at about the location of the hymen, extending the full length of the vagina and into the cervix to the extent of about one-half an inch. I could now pass a finger along one side of the septum to above its upper margin, and with a finger of opposite hand passed along the opposite side, bring the two in contact, showing that the septum was complete. The cervical portion of the septum was at least one-quarter inch in thickness and was now put upon the stretch during uterine contractions, but the vaginal portion remained lax and loose, so much so that one could make

an examination along either side of it and not detect its presence. The patient was now placed under an anæsthetic, and after dilating the cervix to a little larger than the size of a dollar, the forceps were applied and delivery hastened. The application was made without a rupture of the septum, there being plenty of room upon either side of it, but it was felt to give way when traction was attempted; its fibres were severed near the centre, an eight pound child was delivered as rapidly as possible, but it was "stillborn," probably because of the almost continuous contractions of the uterus, the waters having been entirely drained off, it allowed the uterus to contract sufficient to interfere with the fœtal blood supply. After delivery, the edges of the septum were trimmed off as closely as could be done, and sutured with a continuous catgut suture along each margin. The patient made an excellent recovery, no symptoms appeared to show that there had been anything more than a perfectly normal labor.

LXIII. The obstetrician's obligation to the gynæcologist. By Dr. Sarah Hobson.—*Case 1.* Mrs. A., thirty-one, married at eighteen, two children, seven and nine; patient nervous, subject to migraine and frequent attacks of pelvic pain. Examination revealed laceration of perineum and cervix, endometritis. The cervix and perineum were repaired and the vaginal space narrowed.

Case 2. Mrs. R., thirty-two, three children; history of headaches and menorrhagia since last delivery, eight years ago; lacerated perineum and cervix, subinvolution, endometritis. The endometritis improved under local treatment. Trachelorrhaphy and perineorrhaphy restored the orifices.

Case 3. Mrs. C., thirty years; history of profuse leucorrhœa since forceps delivery four months previous to consultation; laceration of perineum and cervix with cervicitis. The operation for repair was delayed for a few months, the patient being assured by the surgeon that conception would not occur in the presence of so extensive a laceration. In the course of four or five months it was again postponed on account of pregnancy. The second labor was easy and rapid, lasting only two hours.

Case 4. Mrs. S., twenty-five; history of backache and easy fatigue since forceps delivery of twins, fifteen months before. Laceration of the perineum had been repaired directly after delivery and recovery was prompt. Exami-

nation showed a lacerated cervix, slight prolapsus and retroversion. The case went back to the family physician, a practitioner of long experience and a surgeon of some repute. He pronounced the condition "ulceration of the womb" and gave local treatment.

Case 5. Mrs. L., thirty five, primipara; tedious labor, breech presentation; laceration of perineum which was repaired directly with good result. After two months she reported according to agreement. There was laceration of the cervix, endometitris and retroversion. Only slight improvement followed six weeks of local treatment. At the end of that time the uterus was curetted and the cervix repaired. The uterus was still in retroversion. For two months the patient came two and three times a week for replacement by tampons. The uterus was then in position, and the woman's health for twelve months has been as good as before pregnancy.

The first and second cases, both neurotic and of long standing, were relieved of pelvic symptoms by the operation. But they have not received systematic attention since leaving the hospital and in neither case is the general health fully restored. The third is an instance of neglect on the part of the obstetrician, either to report the perineal laceration, or to suggest an examination after involution. In the fourth, notwithstanding the long experience of the family physician, I do not accept his diagnosis, "ulceration of the womb." The fifth should be typical. An intelligent woman, a primipara at thirty-five, placed herself under medical supervision during pregnancy, reported two months after delivery, attended promptly to the necessary repair, and now, eighteen months after parturition, is in absolute good health. I have generally found women of broad education more careful to report after delivery and more diligent to observe hygienic conditions; they are, moreover, least likely to come asking for abortion, nor are they disposed to take the matter into their own hands to procure it at any cost.

Every obligation of the obstetrician to the gynæcologist is first a duty to the patient to restore the integrity of each pelvic organ and function. Pregnancy and labor

commonly furnish a conclusive test of a woman's physical well being. The physician who conducts a delivery to a successful termination has a vantage point for instruction which the gynæcologist does not possess. Whatever is true of delivery at term is equally true in the treatment of abortion, inasmuch as "post-abortion lesions are apt to be more disastrous than post-partum."

Failure to secure asepsis may lead to vaginitis, to cellulitis, this in turn to retroversion, or to endometritis. Neglected laceration of the perineum tends to prolapsus and its consequences.

Of laceration of the cervix, Emmet writes: "One-half the ailments of women who have borne children are to be attributed to this lesion." Its train of consequences is long, retarded recovery, subinvolution, painful cicatrices, sclerosis, endometritis, cystic degeneration. Carcinoma of the cervix is generally concomitant to a laceration.

In the résumé from the clinic of the medical diseases of women, published in the January CLINIQUE, out of one hundred and ninety cases cited, cervical and perineal laceration were found in eighty-four, prolapsus in seventy. In forty-two cases from surgical clinic in gynæology, reported in the CLINIQUE for the past two years, twelve were immediately post-puerperal and included pelvic abscess, intermenstrual sepsis, secondary perineorrhaphy and trachelorrhaphy, chorea and salpingitis, prolapsed ovary, cysto-sarcoma, myo-sarcoma and extra-uterine pregnancy.

If, as Lusk says, most sins of midwifery occur in the management of normal labors, the obstetrician should have supervision of the patient in every instance from the beginning of pregnancy until three months after delivery. Many patients who report early in pregnancy will not return after recovery. The united effort of obstetrician and gynæcologist may finally effect a more general appreciation of preventive measures. To this end there should be on the part of the obstetrician:

1. General supervision of pregnancy with special reference to neurotic and urinary tendencies.

2. Scrupulous care in maintaining asepsis during delivery.

3. Exercise of any reliable hygienic or remedial expedient to shorten the first stage.

4. Watchfulness during labor to hasten delivery when delay threatens the integrity of the tissues.

5. Non-interference in any stage when the point at issue is the doctor's convenience.

6. An exact record of the puerperium.

7. Examination of the patient three months after parturition.

DISCUSSION: Dr. LUDLAM: If our good friend Dr. Hobson had written upon the obligation of the gynæcologist to the obstetrician the discussion of this paper would have been more easy and commonplace. But for the blunders and the shortcomings of those who practiced midwifery in the old way the gynæcologist would not have had such a vogue, and some of us might have died in the poor-house.

However, inversely and by way of compensation, the gynæcologist *has* been of the greatest possible service to the science and the art of obstetries. He has enabled us to study the peculiar local conditions that prevent and complicate conception, pregnancy and parturition. He has revived the idea of Prof. Simpson that labor is essentially a surgical operation, and has brought all that belongs to it, before, during and after delivery, within the provident scope of an aseptic technique. He has given us the whole clinical and dramatic history of extra-uterine pregnancy, its tubal and other lesions, and its most proper and successful treatment. He has furnished a new and a most practical system of puerperal pathology; perfected the old Cæsarean section; proposed and practiced the removal of the gravid uterus; rehabilitated symphysiotomy and certain minor obstetric operations which once were so fatal that they had to be abandoned; taught us when to use the Trendelenberg posture, the hot water douche, and the intravenous injection of the saline solution for post-partum

hæmorrhage. He has helped to banish the perforator, the cranioclast and the blunt hook, the dirty forceps, the unclean hands and finger-nails, the infected linen and accessories of the doctor and the nurse from the lying-in chamber; or, in other words, he has taught those who are willing to learn about all that there is of puerperal prophylaxis.

So that, as I take it, the honors are more than easy, and humanity is the gainer. And not only have the disciples of Sims and McDowell, Spencer Wells and Tait contributed to the perfection and the safety of obstetric medicine and surgery; but they will help to establish sound and correct ideas of prognosis as a part, and a very essential part, of obstetric practice.

Dr. LEAVITT: It is quite true that the obstetrician is under great obligations to the gynæcologist. It will be observed that advancement in practical midwifery, which has been so pronounced during the past decade or two, has followed closely upon the remarkable improvements in gynæcology. The one factor which has contributed most generously to the betterment of obstetric results, namely, antiseptic and aseptic practices, owes its introduction very largely to gynæcology. The accoucheur has been quite inclined to follow beaten paths, and, while he would eventually have been inspired to adopt more cleanly practices from the influence of the general surgeon, the prudent step would have been disastrously delayed. But gynæcology, owing to its close relation to obstetrics, soon brought about a reformation which has doubtless preserved many lives.

Again the gynæcologist has taught the obstetrican to be more exact and painstaking in his work. That is to say, he has infused into the latter a surgical spirit. There was a time when no attention was given to repair of parturient lacerations, and even when repair of such lesions became common, for a long time the work was very imperfectly performed; but now immediate perineorrhaphy is usually done with extreme care, and the wound is as thoroughly closed as in the secondary operation.

Furthermore, a few years ago most of the acute puerperal diseases were included under the general title, "puerperal fever," and close distinctions were not often attempted. But this has all changed, and our present ability to recognize puerperal lesions and to differentiate them according to the character of the invasion and the nature of the tissues involved, is due as much to the ante-mortem dissections of the gynæcologist as to the post-mortem examinations of the pathologist.

Dr. CORNELIA S. STETTLER: Dr. Hobson has covered the points made in her paper so well that there is little opportunity for further discussion. The cases given are practical, and the conclusions are sound and trustworthy. The idea that there is more satisfaction in treating an intelligent class of patients, to whom we can explain our views and who will appreciate what we do for them better than the opposite class, is a good one. Fortunately homœopathy commends itself to that kind of people, and it is all the greater pleasure to work among them and for them.

Dr. HOBSON (in closing): The thought of the paper was the obstetrician's obligation to bring the patient early to the gynæcologist that the pelvic repair may be as perfect as possible; also to clear up obscurity in ætiology by the accuracy of the puerperal record; and incidentally perhaps by good management to save the woman from becoming a gynæcological patient.

The obstetrician, it is true, is often the gynæcologist also, which simplifies matters. But it is the gynæcologist who has had extraordinary opportunity in his particular line, who has laid upon the obstetrician the obligation to be an up-to-date surgeon. We are particularly fortunate to have had these points emphasized to-night by two who out of wide experience speak with so great authority.

VOLUNTEER PAPERS. LXIV. PRESENTATION OF APPENDICULAR SPECIMENS. BY DR. CHISLETT.—The four pathological specimens representing different forms of disease of the vermiform appendix have been peculiarly interest-

ing to me and I hope may prove so to the members of this society. Two of them represent the acute forms of appendicitis and two of them the chronic forms.

Case 1. The first and largest one which is a typical representation of gangrenous appendicitis was removed from a young man aged twenty-one. He had been sick about forty-four or forty-eight hours and presented a typical picture of acute appendicitis. The operation disclosed the appendix as you see it dark, practically gangrenous with a distinct perforation in the upper portion through which we may see a large fæcal concretion exposed. The right iliac fossa was full of blood, pus and fæcal matter, the general peritoneum being carefully walled off with iodoform gauze packing. The patient made an uneventful recovery.

Case 2 represents an acute appendicitis without perforation. This appendix was removed from a young man also twenty-one years of age. He had for some months a grumbling pain in the right inguinal region. The acute symptoms developed about thirty-six hours before the operation. The attack was typical, having all of the characteristic symptoms, the most pronounced of which was the absolute constipation. The specimen is peculiarly interesting on account of the beautifully injected condition of the arterial system. No doubt the vessels are in a thrombosed condition else the alcoholic solution in which it has been kept would have caused a bleaching. I have preserved the specimen intact in order to demonstrate this condition of the blood vessels. There is no doubt, however, in my own mind that section of the lower third which you will notice is considerable darker than the rest of the appendix, would reveal a purulent collection. The patient made an uninterrupted recovery. In connection with these two cases of acute appendicitis it seems to me proper to state that there is no one symptom and no group of symptoms by which we can absolutely say how far the inflammatory process had progressed. We can always by careful examination make a diagnosis of appendicitis in the first twelve or twenty-four hours, but I believe it impossible for any man in these early hours to determine absolutely whether we have to deal with a simple, with a suppurative or the gangrenous form. It therefore seems to me plain that one's first duty after a conscientious diagnosis is an immediate operation.

Case 3. This appendix was removed from a woman

aged thirty-six. She has never had symptoms of unusual severity but has had for several years attacks of acute pain in the right inguinal region accompanied by a little nausea and some fever, but would always be well in two or three days. After the first attack, however, there was some tenderness which in all these years has never entirely disappeared. The appendix was found very adherent and as you will see from the specimen the cavity is entirely obliterated and devoid of mucous membrane for the lower three-fourths of an inch. The recovery was uninterrupted.

Case 4. This specimen is a product of an inflammation extending over a period of seven years. For the last two years this young man aged twenty-one has been unable to attend to his business, slight over-exertion of any kind precipitating an attack which would confine him to bed for from two to seven days. The exertion of getting here from Iowa brought on one of these acute attacks and when he entered the hospital his temperature was 101°. A few days of rest brought him to practically a normal condition, when the appendix was removed. It was found twisted around like a cork screw and very adherent. About one inch in the fresh specimen was completely obliterated in the lower third of the appendix. You will see from the specimen, it consisted of two cavities, one just at the tip and the other along the upper two-thirds, the obliterated space having been converted into a fibrous cord connecting the two. This patient has gone home and gone to work.

Case 5. The fifth and last specimen which I bring for your inspection is a beautiful demonstration of a ruptured tubal pregnancy. The patient was about thirty-five years old, the mother of three children, and when she was taken with sudden pain and collapse it was just about the time of the normal menstrual period. An operation was immediately performed, though the woman was practically moribund. The abdomen being opened as quickly as possible, the clamps were at once applied to the broad ligament, thus arresting the hæmorrhage. The wound was then covered with hot sponges while we gave the patient a quart of hot salt solution into the median basilic vein. The loss of blood, however, had been so extreme that the patient died even during the intravenous injection. In the abdomen full of clotted blood we could not find the fœtus, but the specimen demonstrates very nicely the rupture of tubal pregnancy and the necessity for early diagnosis and immediate operation in such cases.

Editorial.

THE HAHNEMANN HOSPITAL, CHICAGO.—Last month this favored institution, which is the grand representative of Homœopathic Medicine and Surgery in the Northwest rounded out its twenty-seventh year. During that period, with all its vicissitudes, its doors have never been closed day or night to the sick and needy poor; and the amount of clinical and charitable work done within its walls has been truly remarkable. From a small beginning in which some old wooden buildings were given rent free by one of its board of trustees, the Hon. J. Y. Scammon, to the occupation of its present quarters, that were new three years ago, the greatest possible difference has existed as to the comforts and facilities provided for its inmates and for its medical and surgical requirements.

The Hospital had a hard struggle at first, but from the summer of 1876, when its loyal friends and alumni became imbued and unified with the proper spirit, its growth and development have been of the most gratifying character. At present its reputation is second to none of the old and responsible public charities of this city, which is saying a great deal, for Chicago is as well equipped with large and flourishing hospitals as any other city in this country.

From its Report for the year 1897 we glean a few facts that will show what a variety of clinical cases of all kinds have been treated therein. Each of its special departments, of which there are six, is run like a separate hospital, with its medical and surgical heads and assistants, its band of trained nurses, private rooms and public wards, and its teaching and operating outfit, but all are under one general management. Like the wheels of a coach, these several departments carry the load without friction or interference, an arrangement that works to perfection. Each of them also has its "Circle" of lady friends and outside workers of whom there are about 300 active, earnest women in this city alone, and, "if they are for us who shall be against us?" But, here is a partial list of the diseases and conditions, medical and miscellaneous, that have been treated and cared for during the year:

Clinical Medicine has furnished typical cases of neuras-

thenia, bronchitis, typhoid fever, typho-malarial do., pneumonia, typhoid do., dysentery, peritonitis, erysipelas, paralysis, epilepsy, Jacksonian do., apoplexy, meningitis, gastritis, gastric catarrh, Bright's disease, tuberculosis, marasmus, exophthalmic goitre, Raynaud's disease, rheumatism, gonorrhœal do., aortic stenosis, mitral insufficiency, angina pectoris, etc.

In Obstetrics the clinics have been more numerous and interesting with a greater variety of cases than ever before, and the number of private patients has also increased. The sub-classes have assisted in the application of the forceps in seventy-three cases.

Diseases of Children. In this department many cases have been treated: hydrocephalus, paralysis, epilepsy, rhachitis, chorea, bronchitis, catarrhal pneumonia, tuberculosis, scabies, ichthyosis, pulmonary atelectasis, syphilitic marasmus, ozœna, etc., etc.

General Surgery has afforded extraordinary advantages to the student and the post-graduate. Besides many minor operations the list includes: cholecystotomies (7), choledochotomies, (2), for radical cure of hernia (15), strangulated hernia (4), resections of the intestine (2), gastrotomy, œsophagotomy, Kraske's operation for excision of the rectum, amputation at the hip joint, nephrectomies (3), nephrolithotomy, excision of the rectum for prolapse, operations for appendicitis (20), excision of aneurism, cystotomies, (4), laminectomy for fracture of the spine, craniectomy for epilepsy and idiocy, etc., etc.

Gynæcology was represented medically and surgically by a large list of cases from which the following are selected: ovariotomies (25), abdominal and vaginal hysterectomies (17), laparotomies for various conditions, (42), curettement (19), extra-uterine pregnancy, recto and vesico-vaginal fistulæ, trachelorrhaphy and perineorrhaphy (27), uterine carcinoma, uterine fibroids, amputation of the cervix, ventro-fixation, hystero-epilepsy, specific and catarrhal salpingitis, vaginal and abdominal exploratory incision, atresia and stenosis of the cervix, cystoscopy, etc., etc.

The *Eye* and *Ear* and the *Throat* and *Nose* clinics, especially in the out-department of the hospital, are more full, interesting, modern and practical than they have ever been, and the operative work is most skillful and satisfactory. In the sub-clinics that are held daily, especial facilities have been furnished in the ophthalmoscopic diagnosis of cerebral disease, and in the refractive work that have never been given in our clinics before.

It is an interesting indication for the continued prosperity of this Hospital that it has such a remarkable showing in a clinical way. To its faithful Board of Trustees, its professional staff, its excellent Superintendent and Matron, its devoted friends, and its alumnæ, who have brought and sent so many patients from all quarters, the greatest praise and credit are due. For without these combined influences no such measure of success could possibly have been realized.

The lessons of this experience are plain and direct. It suggests that this particular hospital has not met with a scant sympathy because it has had the earnest coöperation of a host of earnest men and women; because it has not been conducted for private gain but for the public good; because it has stood for serious, honest, all-around work; and because, for a score of years now, there have been no explanatory duels in its field of operation.

It suggests that the over-multiplication of hospitals is a positive evil. To build, equip and run them properly costs so much of time and money that most of those which are begun are neither useful nor prosperous. They divert and misapply the charitable donations of our generous people; the whole effort is spent on the machinery, and the ultimate effect is disappointing and disastrous. As with our churches and colleges, better a few good, reputable hospitals than hundreds of such as are poor, starving and badly equipped.

It also suggests that only upon the principle of unity and concentration can we ever have adequate centres and resources for the right kind of clinical instruction in our school of practice. With such hospitals as the "Old Hahnemann" of Chicago, and such advantages as it really affords, there is no longer any need or excuse for sending our patients or our pupils to the small concerns that are teaching hospitals by courtesy only and not in fact, or to those of the old-school, in which our medical tenets are either overlooked or abused.

Clinical Reviews.

All books for review, magazines, exchanges, correspondence and articles designed for publication in this journal should henceforth be sent to Dr. R. Ludlam, Editor, 1823 Michigan Avenue, Chicago.

PRINCIPLES OF MEDICINE. Designed for use as a text-book in medical colleges and for the consideration of practitioners generally. By CHARLES S. MACK, M. D., one of the Professors of Materia Medica in the Hahnemann Medical College; Recently Professor of Materia Medica and Therapeutics in the Homœopathic Medical College of the University of Michigan at Ann Arbor. Chicago: The W. T. Keener Company. 1897.

Dr. Sam Johnson is reputed to have said: "Much may be made of a Scotchman if he be caught young." So, we have sometimes thought, of the student of materia medica. If in the beginning he chances to be dowered with brains and to have a good, sensible, well-balanced preceptor, who can discriminate between errors of observation and actual bedside facts, who does not confound the science with the art of Medicine, and who can be an honest practitioner without being a disagreeable partisan, something may afterward be made of him in the college and the hospital. But the proposition remains a conditional one, for if the teacher who represents that important branch in the school is not adapted to his work, and does not interest and properly instruct his pupil, the result will be a failure. Hence the necessity of a thorough and adequate training in this particular department of medical study and research.

Professor Mack's timely little work comprises a series of essays and lectures, some of which are reprinted from our journals, others are new, while all of them are worthy of careful perusal and of preservation. They contain many passages that only want of space prevents us from

copying for our readers. The subjects are: I. Is Homœopathy Exclusive? II. Homœopathy the Only System of Curative Medicine; III. What Shall We Prove? IV. Homœopathy Menaced by Empiricism; V. Empiricism —Rational Practice—Practice under Guidance of Law; VI. How to Study and how to Teach Materia Medica; VII. Need of Definition of the End Sought in any given Practice of Homœopathy; VIII. Considerations on Practice with Dynamic Antagonists in Poisoning by Dynamic Drugs; and IX. An Address to some Students in a Non-homœopathic College.

The object of the book: "To show just what is the cure sought in any given practice of homœopathy; that the cure cannot be intelligently attempted excepting under the guidance of similia as a law; and that one may consistently accept homœopathy and at the same time accept whatever else is good in medicine," is logically and very cleverly fulfilled in these pages. One illustration must suffice:

Dogmatism should have no place in answering questions of science. Discuss these questions with your students, stating the *pros* and *cons* bearing upon each particular point, and try to lead the students to correct conclusions; but let them know that there are, and always will be, many questions unanswered. Don't for an instant let the students suppose that you, or any one else, knows all of, for instance, materia medica pura, or that your opinion or that in a text-book is necessarily final. Teach with confidence the unquestionable facts, but always keep the questionable points distinct from the unquestionable. Hunt down items recorded as pathogenesy to the original sources upon which the record is based, and encourage your students to do the same.

Diseases of the eye. By N. L. MacBride, M. D., of New York. Published by Bœricke, Runyan & Ernesty, New York, 1897. Pages, 310.

This latest volume for the instruction of all interested has merits over any which has gone before it. It is not

unnecessarily technical, has good indications for the remedies given, and is practical.

It is hard to determine how far the compression of what is known on this subject can safely go, but the author seems to have used good judgment in sifting and condensation. While not containing all that the larger works do, it is needless to say that any one mastering its contents will be a very good practitioner in these delicate troubles.

The publishers have made a neat book, and one that every one who desires to treat eye diseases should have in his library. C. H. V.

A TREATISE ON GYNÆCOLOGY, MEDICAL AND SURGICAL. By S. Pozzi, M. D., Professeur Agrégé a la Faculté de Médicine de Paris, etc., etc. Second American edition, translated from the third French edition under the supervision of Brooks H. Wells, M. D., etc., etc. With 600 illustrations. New York: Wm. Wood & Co. 1897. Large 8vo., pp. 936.

The enterprising publishers deserve great praise for giving us a second and improved edition of this excellent book. It has undergone a careful and thorough revision and there are many important additions to the text; some chapters have been rewritten; the pathological anatomy is recent; and the newer modes of operation are described and illustrated in a most satisfactory manner. The translation has been very well made, and some editorial notes have been bracketed with advantage. It is enough to say that since this book first appeared in 1890 it has been translated into five languages, and taken the prizes of the Institute of Medicine and of the Academy of Medicine of Paris. In its present American dress it is a fine, large, noble work, printed on excellent paper with many new and remarkable illustrations.

THE DISEASES OF WOMEN. A Handbook for Students and Practitioners. By J. BLAND SUTTON, F. R. C. S., etc., and ARTHUR F. GILES, M. D., etc., etc. With 115 illustrations. Philadelphia: W. B. Sanders, 925 Walnut Street. 1897. Pp. 436.

Those students and physicians who are in need of a concise manual on gynæcology, will do well to purchase

this compact little volume. It will not only be useful for examination purposes, but also as a ready aid in the practice of that very interesting and important specialty.

THE PIONEERS OF HOMŒOPATHY. COMPILED BY THOMAS LINDSLEY BRADFORD, M. D., Author of "Homœopathic Bibliography of the United States," "Life and Letters of Hahnemann," etc., etc., etc. Philadelphia: Boericke & Tafel. 1897. 8vo, pp. 677.

Part I. of this remarkable book, which is the result of the most painstaking labor on the part of our friend, Dr. Bradford, treats of the "Provers who assisted Hahnemann." There is not only a list of their names and their biographies, but the names of the medicines that were proved by each, are also given. Part II. makes the bulk of the volume and is devoted to the "Pioneer Practitioners of Homœopathy." The story of the lives of these worthies is an intensely interesting one. It gives brief and reliable biographies of all those who practiced this system of medicine prior to the year 1835. The data have been drawn from publications in all languages and are undoubtedly as correct in every detail as it is possible for them to be. The peculiar experiences, sufferings and professional trials of those physicians are vividly portrayed, and after reading them one cannot help feeling proud of the plucky and persevering brotherhood.

This book is a great credit to our homœopathic literature and to our calling. Every physician of our persuasion should not only possess himself of a copy, but should read it most carefully and religiously, and then he will acknowledge his obligation to the faithful and zealous author for what he has done for us.

Miscellaneous Items.

The compliments of the season to our readers far and near.——The section on the Medical Diseases of Women, Prof. Bailey, Chairman, will report at the meeting of the Clinical Society, December 18.——Drs. Strawn, Brooks, Woodard, Sickles and Metcalf are doing excellent and acceptable service as *internes* in the Hahnemann Hospital. ——Two recent events that brought the two schools of medicine together in Chicago were Surgeon General Sternberg's lecture before the Pathological Society on *Yellow Fever*, and the reception to Dr. Nicholas Senn at the Newberry Library.——The medical department of that library now has over 30,000 volumes, 22,000 pamphlets, and more than 400 carefully selected periodicals, including the CLINIQUE.——Removals: Drs. Thos. Ashley, to 242 E. 55th St., city; P. S. Wykoff, from Titusville to New Columbus, Union Co., Pa.; B. W. Dowley, to Bainbridge, Ohio; Hannah J. Payne, to 630 Jackson Bd., city; E. B. Treat, to 241 W. 23d St., N. Y.; F. E. Stoaks, from Harrison, Ark., to Erie, Kansas; and E. L. Hunter, to 362 E. 63d St., city.——We regret to record the death of the excellent wife of our friend, Dr. W. C. Bastar, of Benton Harbor, Mich.——Dr. Hobson's report to the Clinical Society, page 628, is one of the best that we have ever published.——Vol. 51 of the Proceedings of the Literary and Philosophical Society of Liverpool, contains a remarkable paper entitled "Tennyson's Nature Studies," by our friend, Dr. J. Murray Moore.——The death of Prof. Tarnier, of traction-forceps fame, is announced.

The CLINIQUE will continue to appear regularly on the 15th of each month, freighted with practical and useful matter for the busy and earnest physician. Subscriptions and dues should be sent to Dr. C. Gurnee Fellows, Business Manager, 70 State St., Chicago.

VALEDICTORY FOR 1897.—Thanks to our good friends everywhere, the Editorial Committee, the Clinical Society, the College and Hospital management; our faithful and loyal band of Clinical Teachers; our fat list of subscribers, new and old; and to our excellent Business Manager, Dr. C. Gurnee Fellows, Volume XVIII. of the CLINIQUE, which closes with this issue, is fully up to its own traditions as a thoroughly modern and practical publication.

The volume for 1897 has furnished our readers with *twenty-five* clinical lectures; *sixty-four* practical papers that were presented and discussed before the Clinical Society during the year; *one hundred and fifty* clinical cases from the private and hospital practice of its members and correspondents; *twenty-seven* lively editorials on appropriate topics; and a lot of hospital notes, illustrations, portraits, clinical reviews, translations, clinical chips and correspondence, both domestic and foreign. Its complete book-index attests its fitness for a place with its predecessors on the shelf of the reference library, and we herewith commend it to the tender mercies of those who surely will need to consult it again and again.

The success of the CLINIQUE in its own particular field exemplifies and justifies the need of a journal that is neither controversial nor commercial, newsy, trifling, nor transient in character. Its eighteen volumes, that average 500 closely printed pages each, almost 10,000 pages, stand for what has been gleaned and garnered in the best interests of our literature and of the profession. And, while the claims of the physical sciences are so importunate, it cannot be denied that those of clinical medicine, obstetrics and surgery are equally urgent and important. If our many readers will continue their grateful and generous support and encouragement, we promise them that their favorite organ shall hold fast to the faith of its founders and shall in nowise degenerate.

INDEX.

ABDOMINAL chorea, agaracine, case, 466.
Abdominal wounds, objections to the catgut sutures for closure of, case, 58.
Abscess, mammary, treatment of, 536.
Abscess of the liver emptied through bronchial tubes, secondary tubercular infection of the lung, case, 117.
Abscess of the liver, hepatotomy, case, 522.
Actea racemosa in chorea and rheumatism, case, 467.
Acute infectious osteomyelitis, excision of tibial shaft, case, 281.
Address by the Dean of the Faculty, 211.
Adenoid growths causing nasal stenosis, case, 582.
Agaracine, abdominal chorea, case, 466.
Alkaloid antagonistic action of the, 480.
Alumni Association, meeting of the, 220.
Amputation of hip joint by Wyeth's method, case, 520.
Anæmia, cases of, 22.
Anæmia, functional disorders of, and their diagnostic significance, 30.
Anæmia, the pathology of, 25.
Anæsthesia and homœopathy, 604.
Angina pectoris due to tobacco, 491.
Ankle and knee joints, tuberculosis of the, case, 607.
Annis, Dr. A. S., formaldehyde in carbuncles, case, 423.
Antagonistic action of the alkaloids, 480.
Aortic stenosis, case, 115.
Aortitis, chronic, and atheroma and arterio-sclerosis, case, 389.
Appendicitis, acute, gangrene, case, 530.
Appendicitis, second operation for, case, 229.
Appendicitis, the pathogenesis of, 370.
Appendicular specimens, presentation of, 649.
Appointment of medical committee, 546.
Appointment of Prof. W. E. Taylor as Warden of new State Insane Asylum, 207.
Arnold, Dr. R., eye-strain with peculiar reflex symptoms, case, 478.
Arnulphy, Prof. B. S., abscess of the liver emptied through bronchial tubes, secondary tubercular infection of the lung, case, 117.
aortic stenosis, case, 115.
chronic aortitis, atheroma and terio-sclerosis, case, 389.
chronic bronchitis, incipient turberculosis, etc., case, 334.
complex organic lesion of the heart, case, 333.
fatty degeneration of the heart, case, 119.
incipient tuberculosis, case, 335.
the nervous phase of asthma, 450.
valvular lesion of the heart, rare case of, 1.
Arthrectomy, tubercular arthritis of the knee, secondary amputation of the thigh, case, 282.
Arthritis, tubercular, varicocele, fascial tuberculosis, case, 278.
Asthma, the nervous phase of, 450.
Atheroma and arterio-sclerosis with chronic aortitis, case, 389.
Atresia, cervical, causing intermenstrual sepsis, case, 378.
Axillary glands, carcinoma of the, and the breast, specimen, 49.

BAILEY, Prof. E. S., tubo-abdominal pregnancy, operation, case, 131.
Banquet and reception, 217.
Barker, Prof. C. F., early diagnosis of spondylitis, case, 199.
occipital pain connected with ear trouble, case, 405.
on real and apparent death, 232.
treatment of mammary abscess, 536.
Bicycle contention, 276.
Blackwood, Prof. A. L., epileptiform seizures from local irritation, case, 470.
prognosis in fractures, 532.
surgical treatment of rhachitis, 262.
Blepharitis following measles, case, 163.
Blood in health and disease, 423.
Brain, removal of foreign body from the, traumatic epilepsy, case, 225.
Breast, carcinoma of the, and axillary glands, specimen, 49.
Bright's disease, pathology and treatment of two forms of, 349.
Broad ligament, dermoid cyst of the, case, 529.
Bronchitis, chronic, incipient tuberculosis, etc ., case, 334.
Bruce, Prof. E. M., gallstones, case, 524.
pathology and treatment of two forms of Bright's disease, 349.
Burt, Dr. W. H., death of, 102.

CATALEPSY with a uterine fibroid, case, 461.
Catgut, sterile, suppuration from, 60.
Catgut sutures in abdominal wounds, objections to, case, 58.
Carbuncles, formaldehyde in, case, 433.
Carcinoma of the breast and axillary glands, specimen, 49.
Carcinoma of the rectum, colostomy, case, 606.
Carcinoma of the tongue, case, 72.
Carcinoma of the upper lip, excision of entire lip, case, 76.
Cerebral syphilis, case, 63.
Cervical sympathetic, total resection of the, for exophthalmic goitre, 316.
Charity, the abuse of medical, 377.
Children, ear diseases in, 406.
Chirurgophobia, 483.
Chislett, Prof. H. R., acute appendicitis, gangrene, case, 530.
acute infectious osteomyelitis, excision of tibial shaft, case, 281.
acute suppurative pyelitis, nephrotomy, case. 280.
appendicular specimens, 649.
carcinoma of the rectum, colostomy, case, 606.
chronic appendicitis complicated by gallstones, case, 531.
dermoid cyst of the broad ligament, case, 529.
double vaginal hydrocele, multiple puncture, case, 607.
gunshot wounds and their treatment, 443, 621.
tubercular arthritis of the knee, arthrectomy, secondary amputation of the thigh, case, 282
tuberculosis of hip joint, fixation and extension, case, 608.
tuberculosis of knee and ankle joints, case, 607.
tuberculosis of testicle, case, 605.
varicocele, tubercular arthritis, fascial tuberculosis, case, 278.
Cholecystotomy, impacted gallstones, case, 518.
Chorea, abdominal, *agaracine*, case, 466.
Chorea, cases, 330, 331.
Chorea and rheumatism, case, 467.
Chorea, hysterical, case, 469.
Chorea, recurrent, with delayed menstruation, case, 53.
Chorea, recurrent, with laryngo-tracheal catarrh, case, 330.
Chorea with clinical observations, cases, 466.
Chronic aortitis, atheroma and arterio-sclerosis, case, 389
Chronic appendicitis complicated by gallstones, case, 531.
Chronic bronchitis, incipient tuberculosis, case, 334.
Cinchona in the puerperal state, 637.
Clapp, Dr. Katherine B., cases of anæmia, 22.
catalepsy with a uterine fibroid, case, 461.

some of the nervous symptoms of inebriety, case, 457.
Clark, Dr. G. Hardy, cinchona in the puerperal state, 637.
Clark, Dr. J. M., nasal stenosis from adenoid growths, case, 582.
stenosis from multiple nasal polypi, case, 580.
Clinic on the diseases of the eye, 163.
Clinics on Gynæcological Surgery for 1896-97, 56, 131, 172, 179, 378, 551, 608.
Clinical chips, 180, 301, 336, 375, 381, 545, 613, 627.
Clinical discussion, 603.
Clinical medicine, introductory lecture on, 501.
Clinical notes on tertiary syphilis, case, 87.
Clinical Reviews, 112, 166, 222, 337, 382, 492, 655.
Clinical Society, President's Address to the, 354.
Clinical Society Transactions, 22, 81, 131, 181, 239, 302, 354, 405, 457, 518, 578, 628.
Clinical Society, twentieth anniversary of the, 103.
Cobb, Prof. Jos. P., annual report of the Registrar, 213.
anterior poliomyelitis, case, 54.
chorea, cases, 330, 331.
recurrent chorea with delayed menstruation, case, 53.
recurrent chorea with laryngotracheal catarrh, case, 330.
rhachitis, cases, 484, 488.
rhachitis, its etiology and pathology, 239.
rhachitis of a mild type, case, 485.
rhachitis with eclamptic seizures, case, 486.
College nuisance, the, 328.
Collins, Prof. C. D., clinical notes on tertiary syphilis, case, 87.
Color in dress, 354.
Colostomy, carcinoma of the rectum, case, 606.
Colwell, Dr. C. E., disease prevention and what we are coming to, 181.
Commencement Exercises for 1896-97, 211.
Correspondence, 60.
Crawford, Prof. A. K., regarding the death of Prof. W. A. Dunn, 208
cerebral syphilis, case, 63.
color in dress, 354.
Hahnemann and homœopathy, 559.
President's address to the Clinical Society, 354.
Creed, a good medical, 21.
Crofton, Prof. A. C., functional disorders of anæmia and their diagnostic significance, 30.
suppuration from sterile catgut, 60.
uratic diathesis, 8.
Cystitis, gonorrhœal, cystotomy, case, 230.
Cysto-carcinoma of both ovaries with parovarian cyst, case, 155.
Cystotomy, gonorrhœal cystitis, case, 230.

DEATH of Prof. Wesley A. Dunn, 208.
Death, real and apparent, 232.
Degree, conferring of the, 216.
Dermoid cyst of the broad ligament, case, 529.
Diagnosis and treatment of gallstones, 341.
Disease prevention and what we are coming to, 181.
Dogmatic theology as a branch of medical study, 547.
Double pyosalpinx, tuboövariotomy, case, 179.
Double vagina and cervix, labor complicated, by a, 643.
Double vaginal hydrocele; multiple puncture, case, 607.
Drainage, retro-uterine, 152.
Drugs, essential pathogenesy of, 615.
Dunn, Prof. Wesley A., In memoriam of, 208.

EAR diseases in children, 406.
Ear trouble and occipital pain, case, 405.
Eclamptic seizures and rhachitis, case, 486.
Editorials, 51, 103, 161, 209, 276, 328, 376, 434, 480, 546, 603, 652.
Epilepsy, psychic, case, 108.
Epilepsy, the medical treatment of, 295.
Epilepsy, traumatic, removal of foreign body from the brain, case, 225.

Epileptiform seizures from local irritation, case, 470.
Essential pathogenesy of drugs, 615.
Ether, sulphuric, in mushroom poisoning, case, 481.
Etiology and pathology of rhachitis, 239.
Evans, Prof. C. H., a consideration of ferric therapeutics, 320.
clinical view of rhus toxicodendron, 15.
essential pathogenesy of drugs, 615.
observations on sulphur, 367.
opium and its extractives, 507.
pathogenesis of lycopodium clavatum, 122.
Exophthalmic goitre, total bilateral resection of the cervical sympathetic, 316.
Experimental research and literature in medicine, 105.
Extractives of opium, 507.
Extra-uterine pregnancy and intra-ligamentous cyst as sequel, case, 154.
Extra-uterine pregnancy and the gynæcologist, 548.
Extra-uterine pregnancy, rare cases of, 132.
Eye and ear clinic, 549.
Eye, foreign body in fundus of the, for eight years, case, 600.
Eye muscles in disease, 414.
Eye-strain with peculiar reflex symptoms, case, 478.

FALSE prophecy in obstetrics, 628.
Fascial tberculosis, varicocele, tubercular arthritis, case, 278.
Fatty degeneration of the heart, case, 119.
Fellows, Prof. C. Gurnee, blepharitis following measles, case, 163
glaucoma, lecture on, 169.
Ferric therapeutics, a consideration of, 320.
Fibroid, uterine, and cataleptic attacks, case, 461.
Fibroid, uterine, twenty years old, case, 554.
Fibromata, uterine, neurotic conditions incident to, 471.
Foreign body causing toothache and alveolar mischief, case, 579.
Foreign bodies in fundus of the eye for eight years, case, 600.
Foreign bodies in the respiratory passages, 583.
Foreign correspondence, 386, 437, 489.
Formaldehyde in carbuncles, case, 433.
Forsbeck, Dr. F. A., foreign bodies in the throat and nose, 578.
Fractures, prognosis in, 532.
Functional disorders of anæmia and their diagnostic significance, 30.

GALLSTONES, case, 524.
Gallstones complicating chronic appendicitis, case, 531.
Gallstones impacted in cystic duct, cholecystotomy, case, 518.
Gallstones, the diagnosis and treatment of, 341, 567.
Grangrene, spreading, following injury to the leg, case, 525.
Gastritis, septic, as a contingent of ovariotomy, case, 551.
Gilman, Prof. J. E., Hodgkin's disease cured by internal remedies, 44.
the Roentgen ray in its therapeutic application, 360.
Glaucoma, lecture on, 169.
Gonorrhœal, oöphoro-salpingitis, double tubo-ovariotomy, case, 609.
Gonorrhœal cystitis, cystotomy, case, 230.
Gunshot wounds and their treatment, 443, 621.
Graduates, list of the, 214.
Gynæcological Surgery, clinics on, 172, 179, 378, 551, 609.
Gynæcologist, extra-uterine pregnancy and the, 548.
Gynæcologist, obstetrician's obligation to the, 644.
Gynæcology, some compensation for the operative craze in, 397.

HABIT diseases, 51.
Hahnemann Hospital, the Chicago, 652.
Halbert, Prof. H. V., abdominal chorea, *agaracine*, case, 466.
chorea and rheumatism, case, 467.
chorea with clinical observations, case, 466.
clinical medicine, lecture on, 501.

hysterical chorea, case, 469.
Raynaud's disease, case, 573.
the medical treatment of epilepsy, 295.
the relation of psoriasis and myxœdema, 95.
Halphide, Prof. A. C., rhachitis, its morbid anatomy and histology, 244.
the blood in health and disease, 423.
the pathology of anæmia, 25.
Haseltine, Dr. B. D., ear diseases in children, 406.
Heart, complex organic lesion of the, case, 333.
Heart, fatty degeneration of the, case, 119.
Heart, valvular lesion of the, rare case of, 1.
Hendy, Dr. Clara, mouth-breathing with hypertrophy of tonsils, case, 581,
Hepatotomy, abscess of the liver, case, 522.
Hip joint, amputation by Wyeth's method, case, 520.
Hip joint, tuberculosis of the, fixation and extension, case. 608.
Histology and morbid anatomy of rhachitis, 244.
Hobson, Dr. Sarah, obligation between the obstetrician and gynæcologist, 644.
Hodgkin's disease cured by internal remedies, 44.
Homœopathy and anæsthesia, 604.
Homœopathy and Hahnemann, 559.
Honberger, Prof. F. H., symptoms of rhachitis, 250.
labor complicated by double vagina and cervix uteri, case, 643.
Honeymoon, the professional, 277.
Hospital Notes, 53, 107, 163, 278, 330, 378, 484, 549, 605.
Humerus, necrosis of the, with acute osteo-myelitis, case, 78.
Humerus, osteo-sarcoma of the, case, 527.
Hydatid of Morgagni, cyst with suppurative ovaritis and salpingitis, case, 177.
Hydrocele, double vaginal, multiple puncture, case, 607.
Hygienic and medical treatment of rickets, 256.
Hypertrophy of the tonsils and mouth-breathing, case, 581.
Hysterectomy, the propriety of, in certain neurotic affections, 611.
Hysterectomy, vaginal, four special cases of, with three recoveries and one death, 172.
Hysterical chorea, case, 469.

INCIPIENT tuberculosis, case, 335.
Incipient tuberculosis, chronic bronchitis, case, 334.
Inebriety, some of the nervous symptoms of, case, 457.
In memoriam of Prof. Wesley A. Dunn, 209.
Institute, the meeting of the, 376.
Inter-menstrual sepsis from cervical atresia, case, 378.
Intraligamentous abscess the sequel of extra-uterine pregnancy, case, 154.
Introductory Lecture by Prof. C. H. Vilas, 495.
Irritation, local, causing epileptiform seizures, case, 470.

KAHLKE, DR. C. E., osteo-sarcoma of the humerus, case, 527.
spreading gangrene following injury to leg, case, 525.
Knee and ankle joints, tuberculosis of the, case, 607.
Knee, tubercular arthritis of the, arthrectomy; secondary amputation of the thigh, case, 282.

LABOR, complicated by a double vagina, and cervix, 643.
Laryngo-tracheal catarrh with recurrent chorea, case, 330.
Leavitt, Prof. S., symphysiotomy, 141.
the question of vaginal incision, 303.
Leg, injury to the, followed by spreading gangrene, case, 525.
Lip, carcinoma of the upper, excision of the entire lip, case, 76.
Literary and experimental research in medicine, 105.
Liver, abscess of the, emptied through bronchial tubes, secondary tubercular infection of the lung, case, 117.

Logical bias in medicine, the, 285.
Liver, abscess of the; hepatotomy, case, 522.
London, post-graduate work in, 106.
Ludlam, Prof. R., an objection to catgut sutures in the closure of abdominal wounds, case, 58.
cysto-carcinoma of both ovaries with parovarian cyst, case, 155.
double pyosalpinx, tubo-ovariotomy, case, 179.
four special cases of vaginal hysterectomy with three recoveries and one death, 172.
gonorrhœal oöphoro-salpingitis, double tubo-ovariotomy, case, 609.
inter-menstrual sepsis from cervical atresia, case, 378.
intraligamentous abscess the sequel of extra-uterine pregnancy, case, 154.
large multilocular ruptured ovarian cyst with ascites and procidentia uteri, case, 155.
ovarian surgery in osteomalacia, 270.
rare cases of extra-uterine pregnancy, 132.
report of clinics on Gynæcological Surgery, 56, 131, 172, 378, 551.
retro-uterine drainage, 152.
septic gastritis as a contingent of ovariotomy, case, 551.
some of the compensations for the operative craze in gynæcology, 397.
suppurative ovaritis and salpingitis with a cyst of the hydatid of Morgagni, removal, recovery, case, 177.
the logical bias in medicine, 285.
the propriety of hysterectomy in certain neurotic cases, 611.
the surgical importance of discriminating between sexual and menstrual neuroses, case, 56.
tubo-abdominal pregnancy, fœtal extraction through the vagina, case, 556.
uterine fibroid twenty years old, case, 554.
Ludlam, Prof. R. Jr., multilocular ovarian cyst with endogenous cysts in the compartments, case, 316.
neurotic conditions incident to uterine fibromata, 471.
new method of ligating the pedicle in tubo-ovariotomy, 137.
parovarian cysts, cases, 315.
Tait's operation in extreme cases, 316.
Lung, secondary infection of the, with abscess of the liver emptied through the bronchial tubes, case, 117.
Lycopodium clavatum, pathogenenis of, 122.

MACK, Dr. Chas. H., operation for ingrowing toe nail, 160.
uræmic poisoning, cases of, 273.
Magnesia phos. in spasms, case, 158.
Mammary abscess, the treatment of, 536.
Measles followed by blepharitis, case, 163.
Medical and hygienic treatment of rickets, 256.
Medical treatment of epilepsy, 295.
Medicine, literary and experimental research in, 105.
Medicine and surgery in the treatment of cancer, 434.
Medicine and surgery, the numerical wave in, 161.
Medicine, the logical bias in, 285.
Meeting of the Alumni Association, 220.
Meetings of the Clinical Society, 22, 81, 131, 181, 239, 302, 354, 405, 457, 518, 578, 628.
Meeting of the Institute, 376.
Ménière's disease, 539, 596.
Menstrual and sexual neuroses, the importance of discriminating between, case, 56
Menstruation, delayed, with recurrent chorea, case, 53.
Mercurial poisoning and syphilis, cases, 81.
Miscellaneous Items, 62, 114, 168, 224, 284, 339, 388, 442, 493, 558, 614, 659.
Morbid anatomy and histology of rhachitis, 244.

Morbid specimens, exhibition of, 102.
Morgan, Dr. Ada, tonsilar hypertrophy, case, 581.
Mouth breathing with hypertrophy of the tonsils, case, 581.
Multilocular ovarian cyst with endogenous cysts in the compartments, case, 316.
Muscles of the eye in disease, 414.
Mushroom poisoning, sulphuric ether in, case, 481.
Myxœdema and psoriasis, the relation of, 95.

NASAL catarrh from a bit of sponge, case, 579.
Nasal catarrh from the presence of a straw, case, 579.
Nasal polypi causing stenosis, case, 580.
Nasal stenosis from adenoid growths, case, 582.
Nephrotomy; acute suppurative pyelitis, case, 280.
Nervous functional disorders in women, 40.
Nervous phase of asthma, 450.
Nervous symptoms of rhachitis, 253.
Neurasthenia with prominent ocular symptoms, case, 107.
Neuritis, puerperal, 202.
Neurosis, sexual and menstrual, importance of discriminating between, case, 56.
Neurotic conditions incident to uterine fibromata, 471.
New methods of ligating the pedicle in tuboövariotomy, 137.
Nose and throat, foreign bodies in the, 578.
Numerical wave in medicine and surgery, 161.

OBSERVATIONS on sulphur, 367.
Objections to the catgut sutures in closure of abdominal wounds, case, 58.
Obstetrics, false prophecy in, 628.
Obstetrician's obligation to the gynæcologist, 644.
Occipital pain connected with ear trouble, case, 405.
Ocular symptoms with neurasthenia, case, 107.
Oöphoro-salpingitis, gonorrhœal; double tuboövariotomy, case, 609.
Operative craze in gynæcology, some of the compensations for the, 397.
Opium and its extractives, 507.
Original Lectures, 1, 8, 15, 63, 72, 115, 122, 169, 172, 225, 232, 285, 295, 341, 349, 389, 443, 450, 495, 501, 507, 559, 567, 573, 615, 621.
Osteomalacia, ovarian surgery in, 270.
Osteomyelitis, acute infectious, tibial shaft, excised, case, 281.
Osteomyelitis, acute, with necrosis of humerus, case, 78.
Osteo-sarcoma of the humerus, case, 527.
Ovarian cyst, large multilocular ruptured, with ascites and procidentia uteri, case, 155.
Ovarian cyst, multilocular, with endogenous cysts in the compartments, case, 316.
Ovarian surgery in osteo-malacia, 270.
Ovaries, cysto-carcinoma of both, with parovarian cyst, case, 155.
Ovariotomy, septic gastritis as a contingent of, case, 551.
Ovaritis, suppurative, and salpingitis with hydatid cyst of Morgagni, case, 177.

PAROVARIAN cysts, cases, 315.
Parovarian cyst with cysto-carcinoma of both ovaries, case, 155.
Pathogenesis of appendicitis, 370.
Pathogenesis of lycopodium clavatum, 122.
Pathogenesy of drugs, the essential, 615.
Pathology and etiology of rhachitis, 239.
Pathology and treatment of two forms of Bright's disease, 349.
Pathology of anæmia, 25.
Payne, Dr. Hannah J., hygienic and medical treatment of rickets, 256.
nervous functional disorders, 40.
Poliomyelitis, anterior, case, 54
Polypi, nasal, causing stenosis, case, 580.

Post-graduate work in London, 106.
Pregnancy, extra-uterine, rare cases of, 132.
Pregnancy, extra-uterine, with sequel of an intraligamentous cyst, case, 154.
Pregnancy, tubo-abdominal, fœtus extracted through the vagina, case, 556.
Pregnancy, tubo-abdominal, operation, case, 131.
Presentation of appendicular specimens, 649.
Presentation of prizes, 216.
Presentation of rare specimens, 206.
President's address to the Clinical Society, 354.
Prizes, presentation of the, 216.
Professional honeymoon, 277.
Psoriasis and myxœdema, the relation of, 95.
Puerperal convulsions, case, 157.
Puerperal neuritis, 202.
Puerperal state, the selection of remedies for, 637
Pupil, abnormal reaction of the, case, 197.
Pyelitis, acute suppurative, nephrotomy, case, 280.
Psychic epilepsy, case, 108.

RARE cases of extra-uterine pregnancy, 132.
Raynaud's disease, case, 573.
Real and apparent death, 232.
Reception and banquet, 217.
Rectum, carcinoma of the, colostomy, case, 606.
Reflex symptoms from eye-strain, case, 478.
Registrar, Annual Report of the, 213.
Remedies, selection of, for the puerperal state, 637.
Report of the bureau on Sanitary Science, 181.
Report of the Children's Clinics, 53, 330, 484.
Report of the Clinics on Gynæcological Surgery for 1896-97, 179.
Report of Clinics on Gynæcological Surgery, 56, 131, 172, 378, 551,
Report of the Clinics on Thoracic diseases, 333.
Report of the Nervous clinics, 107.
Report of the section on diseases of the Eye and Ear, 405.
Report of the section on Materia Medica and Therapeutics, 360.
Report of the section on Nervous diseases, 457.
Report of the section on Puerperal diseases, 303, 628.
Report of the Surgical clinics, 72.
Respiratory passages, foreign bodies in the, 583.
Retinal detachment, case, 99.
Retro-uterine drainage, 152.
Rhachitis, cases, 484, 488.
Rhachitis, its etiology and pathology, 239.
Rhachitis, its morbid anatomy and histology, 244.
Rhachitis of a mild type, case, 485.
Rhachitis, surgical treatment of, 262.
Rhachitis, the nervous symptoms of, 253.
Rhachitis, the symptoms of, 250.
Rhachitis, with eclamptic seizures, case, 486.
Rheumatism and chorea, case, 467.
Rhus toxicodendron, clinical view of, 15.
Rickets, the hygienic and medical treatment of, 256.
Roentgen ray and its therapeutic application, 360.

SALPINGITIS and suppurative ovaritis with hydatid cyst of Morgagni, case, 177.
Sanitary Science, report of the bureau on, 181.
Selection of remedies for the puerperal state, cinchona, 637.
Sepsis, inter-menstrual, caused by cervical atresia, case, 378.
Septic gastritis as a contingent of ovariotomy, 551.
Sexual and menstrual neuroses, the surgical importance of discriminating between, case, 56.
Shears, Prof G. F., abscess of the liver, hepatotomy, case, 522.
acute osteo-myelitis with necrosis of the humerus, case, 78.
carcinoma of the breast and axillary glands, specimen, 49.
carcinoma of the tongue, case, 72.
carcinoma of the upper lip, excision of entire lip, case, 76.
diagnosis and treatment of gall-stones, 341.

exhibition of morbid specimens, 102.
gallstones impacted in cystic duct, cholecystotomy, case, 518.
gonorrhœal cystitis, cystotomy, case, 230.
hip joint amputation by Wyeth's method, case, 520.
presentation of rare specimens, 206.
report of the Surgical Clinics, 72, 518.
second operation for appendicitis, case, 229.
treatment of gallstones, 567.
traumatic epilepsey, removal of foreign body from the brain, case, 225.
Smith. Prof. O. L., foreign bodies in the respiratory passages, 583.
nervous symptoms of rhachitis, 253.
neurasthenia with prominent ocular symptoms, case, 107.
psychic epilepsy, case, 108.
Spasms, magnesia phos. in, case, 158.
Specimens, presentation of rare, 206.
Spondylitis, the early diagnosis of, case, 199.
Sponge causing nasal catarrh, case, 579.
Spreading traumatic gangrene following injury to the leg, case, 525,
Stenosis, aortic, case, 115.
Stenosis from multiple nasal polypi, case, 580.
Stettler, Dr. C. S., false prophecy in obstetrics, 628.
Ménière's disease, 539, 596.
puerperal neuritis, 202.
the pathogenesis of appendicitis, 370.
Sturtevant, Dr. M. C., magnesia phos. in spasms, case, 158.
puerperal convulsions, case, 157.
Sulphur, observations on, 367.
Sulphuric ether in mushroom poisoning, case. 481.
Suppuration from sterile catgut, 60.
Suppurative ovaritis and salpingitis with hydatid cyst of Morgagni case, 177.
Surgery and medicine in the treatment of cancer, 434.
Surgery and medicine, the numerical wave in, 161.
Surgical clinics, 225.
Surgical importance of discriminating between sexual and menstrual neuroses, case, 56.
Surgical treatment of rhachitis, 262.
Sutures, catgut, objections to, in abdominal wounds, case, 58.
Swan, Dr. C. J., abnormal reaction of the pupil, case, 197.
foreign body in the eye for eight years, case, 600.
retinal detachment, case, 99.
the eye muscles in disease, 414.
total bilateral resection of the cervical sympathetic in exophthalmic goitre, 316.
Symphysiotomy, 141.
Syphilis and mercurial poisoning, cases, 81.
Syphilis, cerebral, case, 63.
Syphilis, tertiary, clinical notes on, case, 87.

TAIT'S operation in extreme cases, 316.
Taylor, Prof. W. E., appointment as warden of the new State insane asylum, 207.
syphilis and mercurial poisoning, cases, 81.
Tertiary syphilis, clinical notes on, case, 87.
Testicle, tuberculosis of the, case, 605.
Therapeutical application of the Roentgen ray, 360.
Thigh, secondary amputation of the, tubercular arthritis of the knee, arthrectomy, case, 282.
Thoracic diseases, report of the clinics on, 333.
Throat and nose, foreign bodies in the, 578.
Tibia, excised, acute infectious osteomyelitis, case, 281.
Tobacco as a cause of angina pectoris, 491.
Toenail, ingrowing, operation for, 160.
Tongue, carcinoma of the, case, 72.
Tonsilar hypertrophy, case, 581.
Tonsils, hypertrophy of the, with mouth-breathing, case, 581.
Toothache and alveolar mischief from foreign body, case, 579.
Total bilateral resection of the cer-

vical sympathetic in exophthalmic goitre, 316.
Traumatic epilepsy, removal of foreign body from the brain, case, 225.
Treatment and diagnosis of gallstones, 341.
Treatment and pathology of two forms of Bright's disease, 349.
Treatment of gunshot wounds, 443, 621.
Treatment of mammary abscess, 536.
Transactions of the Cinical Society, 22, 81, 131, 181, 239, 302, 354, 405, 457, 518, 578, 628.
Tubercular arthritis of the knee, arthrectomy, secondary amputation of the thigh, case, 282.
Tubercular arthritis, varicocele; fascial tuberculosis, case, 278.
Tuberculosis, incipient; case, 335.
Tuberculosis, incipient, chronic bronchitis, etc., case, 334.
Tuberculosis of hip joint; fixation and extension, case, 608.
Tuberculosis of knee and ankle joints, case, 607.
Tuberculosis of the testicle, case, 605.
Tubo-abdominal pregnancy, fœtus extracted through the vagina, case, 526.
Tubo-abdominal pregnancy, operation, case, 131.
Tubo-ovariotomy, double, for oöphoro-salpingitis, case, 609.
Tubo-ovariotomy, double pyosalpinx, case. 179.
Tubo-ovariotomy, new method of ligating the pedicle in, 137.
Twentieth Anniversary of the Clinical Society, 103.
Two hundred hospital patients cured in one day, 435.

URÆMIC poisoning, cases of, 273.
Uratic diathesis, lecture on, 8.
Uterine fibroid accompanied with catalepsy, case, 461.
Uterine fibroid twenty years of age, case, 554.
Uterine fibromata, neurotic conditions incident to, 471.

VAGINAL hysterectomy, four special cases of, with three recoveries and one death, 172.
Vaginal incision, the question of, 303.
Valedictory for 1897, 660.
Valvular lesion of the heart, rare case of, 1.
Varicocele, tubercular arthritis, fascial tuberculosis, case, 278.
Vilas, Prof. C. H., address by Dean of the Faculty, 211.
Introductory Lecture, 495.
Volunteer Papers, 44, 99, 157, 197, 273, 315, 370, 423, 539, 600, 649.

WOMEN, nervous functional disorders in, 40.
Wyeth's method for hip joint amputation, case, 520.